Care in Communities:

Guidelines for National Red Cross Red Crescent Societies

A community health systems approach 2020

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Abbreviations and acronyms

ACT	Artemisinin-based combination therapy
AIDS	Acquired immuno-deficiency syndrome
AMW	Auxiliary midwife
ART	Anti-retroviral treatment
CB-DOTS	Community-based, direct observed treatment, short course (TB)
CEA	Community engagement and accountability
CHV	Community health volunteer
CBHW	Community-based health worker
CIC	Care in Communities
DOTS	Direct observed treatment, short course
HIC	High income country
HIV	Human immunodeficiency virus
HMIS	Health Management Information System
HR	Human resources
iCCM	Integrated Community Case Management
IFRC	International Federation of Red Cross and Red Crescent Societies
LMIC	Low- and middle-income countries
M&E	Monitoring and evaluation
MoH	Ministry of Health
MoU	Memorandum of Understanding
MNCH	Maternal, neonatal and child health
MNS	Mental, neurological and substance use disorders
MUAC	Mid-Upper Arm circumference
NCD	Noncommunicable disease
NTD	Neglected tropical disease
ODK	Open data kit
ORS	Oral rehydration solution
ORT	Oral rehydration treatment
OVC	Orphans and vulnerable children
PFA	Psychological first aid
PHC	Primary health care
PMER	Planning, Monitoring, Evaluation and Reporting
PMTCT	Prevention of mother to child transmission (HIV)
RDT	Rapid diagnostic test

Foreword

For more than one billion people around the world, access to appropriate and quality health services has been hampered by shortages in human resources and the limited availability of health facilities. Projections estimate a potential shortfall of 18 million health workers in low- and lower-middle-income countries if Universal Health Coverage (UHC) is to be achieved by 2030. Achievement of the Sustainable Development Goals (SDG) and UHC will require innovative solutions and a concerted effort from governments and international organizations to meet these demands. A well-trained, community-based health workforce can play a key role in ensuring that these challenges are met in an effective, efficient and timely manner. Studies have demonstrated the effectiveness of community-based health workers in tackling reproductive, maternal and child health issues, communicable and noncommunicable diseases, and in providing rehabilitative and palliative care services.

The International Federation of Red Cross and Red Crescent Societies (IFRC), along with its 192 member National Societies, has long been at the forefront of providing health services to people in varied settings around the world. In 2017, through its large volunteer network, more than 118 million people were reached by the Health and WASH programmes. The Red Cross Red Crescent network is committed to making the "last mile" its collective "first mile" and has access to underserved and marginalized populations through its 13.7 million volunteers.

The Red Cross Red Crescent network's Care in Communities (CIC) programme focuses on community-based health workers, including trained Red Cross Red Crescent volunteers, delivering, at the community level and in varied settings, evidence-based and essential community health interventions throughout people's life course. The CIC guidelines aim to provide National Societies with a framework that uses a systems approach that can be contextualized by programme managers and implemented hand-in-hand with governments and communities. We hope that these guidelines will support National Red Cross Red Crescent Societies in the important and valuable work they are doing in their communities.

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Executive summary

Over one billion people cannot use the health services they need because they are either unavailable or unaffordable. Health workforce deficiencies, inadequate distribution and quality and performance challenges represent some of the main obstacles to the scaling up of essential health interventions. Addressing these challenges is essential for progress towards Sustainable Development Goal 3 to "ensure healthy lives and promote well-being for all at all ages" and to guarantee Universal Health Coverage (UHC).

Projections estimate a potential shortfall of 18 million health workers in low- and lower-middle-income countries if UHC is to be achieved by 2030. Health systems strengthening to address this shortage of human resources for health, with an emphasis on community-based primary healthcare and workforce, is the need of the hour.

Task shifting through the engagement of community-based health workers (CBHWs), including trained community health volunteers and other health workers, is increasingly being recognized for its potential contribution to meeting the urgent health workforce challenges. The IFRC and its member National Societies have a unique advantage among relief, development and international humanitarian organizations in advocating, planning and implementing a task sharing and role delegation approach to Care in the Communities programming. First, they have access to communities that are the most isolated and exposed to disaster risks. Second, the auxiliary role to public authorities, including health authorities, allows them to play an active role in linking those communities to the health system. Third, National Societies can reach the most marginalized and excluded populations through their networks of volunteers.

Red Cross Red Crescent volunteers have a personal understanding of people's needs, circumstances and of the overall social context. As community-based humanitarian organizations which are auxiliaries to the public authorities, National Societies are well positioned to strengthen the links between vulnerable communities, their volunteers and the formal health system. Besides health promotion and education, CBHWs, including trained community health volunteers, can bridge the gap in community-based human resources for health by working together with communities to help them to take charge of their own health, and by providing essential, evidenced-based community health service packages in a timely, equitable, affordable and acceptable manner. Tackling community health requires holistic, complex and comprehensive solutions through a life course approach, focusing on prevention (at primary, secondary and tertiary levels), access to early diagnostic, screening, treatment and care and advocating for policy changes with an enabling environment and innovative solutions to improve access to care.

These guidelines were developed through consultation with and contribution from National Societies, subject matter experts and a range of key stakeholders. The result is comprehensive guidance on the implementation of community-based care and support programmes that are adaptable and suitable for implementation in diverse settings. These guidelines should be used to assist programme managers in National Red Cross Red Crescent Societies in the design, implementation and evaluation of CIC programmes.

The following key recommendations are made in the guidance:

1. Key recommendations on the role of National Societies in community-based care

1.1. A Memorandum of Understanding (MoU) between the National Society and the government should be established. This should include programme objectives, duration, terms of agreement, governing terms, target population, services provided, financial management, budgets, supportive supervision, monitoring and evaluation, supply chain management, logistics, long-term plans, and roles and responsibilities of the National Society and government.

1.2. National Societies should conduct a situational analysis of existing community programming prior to implementation of the guidance in order to identify and understand current policies and practice, capacities, gaps and challenges. This will enable the development of an evidence-based country action plan, which will guide all activities.

2. Key recommendations on the selection and management of CBHWs and volunteers

Selection criteria of CBHWs, including volunteers

2.1. CBHWs should belong to and reside in the target community and speak the local language. Selection should be done with active community involvement and acceptance, paying attention to involve the entire community and not just leaders.

2.2. A target population size for CBHWs should be established for workload management as per National Society policy and the formal health system's recommendations.

2.3. Where possible, recruitment and selection of CBHWs should be in alignment with the selection procedures of the National Society. Selection should be based on the minimum educational qualification deemed necessary for the tasks to be carried out as per the formal health system. Gender equity should be pursued in a way that is appropriate to the context.

Training and competencies

2.4. CBHWs should receive training at the start of the programme and ongoing trainings, including refresher courses, covering both the practical and theoretical aspects of their roles. Where possible, the training should occur within the community or as close to the community as possible. Training should be modular, participatory, interactive, hands-on and follow adult learning methodology.

Incentives

2.5. Consistent and predictable incentives that are appropriate to CBHW tasks and level of training are important for CBHW retention and motivation. A mix of financial and non-financial remuneration is recommended. Those expected to work 20—40 hours per week should be compensated in some way as there is little evidence to support long term volunteerism in such cases.

2.6. Financial incentives should be channelled through the government to the National Society to pass on to CBHWs. This should be clearly mentioned in the Memorandum of Understanding between the Ministry of Health and the National Society.

2.7. National Societies should follow the government's system of CBHW remuneration. All CBHWs should be compensated for expenses incurred when delivering services.

Supportive supervision

2.8. Supervisors may have a clinical or non-clinical background depending on the volunteer level and their identified tasks; however, they must have sound technical knowledge and appropriate training. Peer support and supervision by senior, more experienced CBHWs should be considered.

2.9. Supervisors must be a part of, or linked to, the government system, using the same tools, checklists and quality standards. Preferably, they should also be from the Red Cross or Red Crescent branch office.

2.10. Supervision should be jointly provided by staff from the National Society and primary healthcare facility in the community. For effective CBHW functioning, regular supervision of at least one visit per month is recommended. This will require an appropriate supervisor-CBHW ratio.

2.11. An effective link for referral to and counter-referral from other community-based health services must be established.

Measuring the change: reporting, monitoring and evaluation

2.12. Data collection on CBHW performance and programme indicators must be built into a simplified health management information system (HMIS). Reporting indicators should be decided by the National Society and government health authorities.

2.13. Indicators for CBHW performance should be defined and periodic programme performance evaluation should be conducted to ensure quality standards in CBHW training and programme implementation.

2.14. Regular reports from the CBHWs should be collected by supervisors on a monthly basis at least.

2.15. A results-based management approach must be adopted for all phases of the programme and a Planning, Monitoring, Evaluation and Reporting toolkit should be developed.

3. Key recommendations on enabling effective service delivery

Supply chain mechanism

3.1. To ensure the consistent and uninterrupted supply of commodities (e.g. essential drugs, diagnostic tools and technologies), supply chain mechanisms must be clearly outlined in the Memorandum of Understanding between the National Society and the Ministry of Health. This should be included in the national pharmaceutical supply plan or its equivalent.

3.2. National distribution systems of commodities should address the needs of CBHWs on the ground based on reliable data and forecasting.

Community engagement and accountability

3.3. Programming should adhere to the Red Cross Red Crescent community engagement and accountability approach that puts communities at the centre of all the programmes.

3.4. Good community engagement and accountability practices should involve community consultation before the intervention, sensitization and consultation with community members and key stakeholders, the formation of a community health committee, implementation and assessment with community involvement and sharing outcomes with community members.

Risks and challenges

3.5. CBHWs should not be performing tasks as independent practitioners without clinical oversight and regular quality assessment. National Societies must ensure that CBHWs conducting these services are appropriately trained and supervised. It is the responsibility of governments, with the input of clinical regulatory and health professional bodies, to establish national guidelines and regulations under which CBHW programmes operate.

Ensuring sustainability and analysing conditions for a win-win situation

3.6. The MoU needs to identify mechanisms to continue the programme beyond the end-date such as co-funding, stepwise phased out funding by the Red Cross Red Crescent and exploring other options for funding and partners.

Recommendations to operationalize the guidelines

3.7. All CIC interventions use a life course approach and should adhere to the principles of comprehensiveness, accessibility, coverage, continuum of care, quality, coordination, accountability and affordability.

Essential evidence-based health services packages for delivery at the community/ home levels

3.8. In emergency settings, leaving no one behind and reaching the last mile, as well as marginalized and underserved groups, must be at the centre of all operations. Protracted crises settings will require special approaches to service delivery in order to enhance the accessibility of services.

Part 1: Setting up a CIC programme

Background and rationale

Over one billion people cannot use the health services they need because they are either unavailable or unaffordable[1]. Health workforce deficiencies, inadequate distribution and quality and performance challenges represent some of the main obstacles to scaling up of essential health interventions. Addressing these challenges is essential for progress towards Sustainable Development Goal (SDG) 3 to "ensure healthy lives and promote well-being for all at all ages" and guaranteeing Universal Health Coverage (UHC).

While UHC has been adopted globally, there are wide disparities in health indicators between countries and within countries[2]. In low- and middle-income countries (LMIC), the challenges are related to lack of quality of health services and inadequate financial protection coverage for significant portions of the population. In high-income countries, challenges are related to sustaining and expanding the gains already achieved. Health services are further strained during protracted crises and conflicts, necessitating adaptation of strategies. Within countries, various factors such as wealth, gender, age and geographical location determine access to essential health services.

Projections estimate a potential shortfall of 18 million health workers in low- and lower-middle-income countries if UHC is to be achieved by 2030[3]. Health systems strengthening to address this shortage of human resources for health, with an emphasis on community-based primary healthcare and workforce, is the need of the hour. Investments in a community-based health workforce will result in long-term economic benefits due to increased employment and productivity ensuing from a healthier population by potentially reducing the risk of major health epidemics[4]. This can also result in short-term cost savings in other parts of the health system by reducing number of patients treated at health facilities.

Community-based health workers (CBHWs), which for the purposes of this document include trained Red Cross Red Crescent volunteers, are cost-effective in treating TB, malaria, HIV/AIDS, noncommunicable diseases (NCDs), neglected tropical diseases and conditions related to reproductive, maternal, new-born, child and adolescent health[5,6,7]. Programmatic and clinical indicators for care provided by CBHWs are similar or superior to those of traditional models of health care for TB and malaria[6]. CBHWs are relevant in all settings and in LMICs are engaged in promoting safe birth and exclusive breastfeeding, screening, management and follow-up of uncomplicated childhood illnesses,

malaria, TB, HIV and AIDS, sexually transmitted diseases (STDs) and NCDs, facilitating access to health services and supporting palliative and rehabilitative services. In high- and middle-income countries, they play an important role in NCD prevention and curative services, home-based care of older persons as well as community outreach for remote communities, migrant and refugee populations[8,9,10,11]. The evidence suggests that CBHW cadres globally have more women than men. The CBHWs come from within the communities which they serve. As such, they are very well positioned to understand the contexts and work within socio-cultural (including gender) norms, to increase access to services for community members, especially women[12].

The recent WHO guidelines on health policy and system support to optimize the CBHW programme state that "its relevance and applicability include other types of community-based health workers, defined in the context of this document as 'health workers based in communities' who are either paid or volunteer, who are not professionals"[12]. The health and care priorities of the IFRC are well-aligned with SDGs and UHC[13]. IFRC, with 192 member National Societies, around 170,000 local branches, 465,000 paid staff, and a volunteer network of 13.7 million, reached more than 118 million people in 2017[13]. Its ability, therefore, to influence the conversation on "making UHC a reality on the ground" is significant, and ultimately it has an opportunity to ensure that National Societies are positioned as key implementing partners in their role as auxiliaries to governments.

Goals and objectives

The overall goal of these guidelines is to assist programme managers in National Red Cross Red Crescent Societies to design, implement and evaluate CIC programmes. These community-level programmes will involve community and home-based care and support and task shifting including primary, secondary and tertiary prevention of diseases at the community level.

These guidelines follow a health systems approach to guide National Societies to develop and sustain programmes in all community-based settings, including development, emergencies and protracted crisis/fragile contexts.

The guidelines spell out the relevance of different community-based approaches, the role of IFRC and National Societies, and the roles and responsibilities of CBHWs, including trained Red Cross Red Crescent volunteers. This is all informed by national strategies and nationally agreed systems for monitoring and evaluation.

Objectives: The specific objectives of these guidelines are to:

- Develop/provide a CIC programming framework for the Red Cross Red Crescent network that National Societies may implement in a variety of settings that ensure equitable access to services.
- Articulate relevant contextual elements, implementation and evaluation considerations at the policy and systems level.
- Recommend evidence-based, essential community health interventions relevant to CIC programmes.
- Recommend steps to operationalize the guidelines at National Society level in the context of planning and implementing programmes.

Methodology

The guidelines have been developed in close coordination with and including technical inputs from the Senior Officer, Care in Communities, Health and Care Department, IFRC, while undertaking:

- Critical appraisal and analysis of the evidence using an extensive desktop literature review of relevant materials from within and outside the Red Cross Red Crescent network (existing manuals for CBHWs, guidelines, tools, research studies and other materials).
- Consultations and contributions from Red Cross Red Crescent personnel through interviews, email clarifications, feedback on drafts from a number of National Societies and IFRC country, regional and global focal points from different departments.
- The draft guidelines have also been presented and discussed at length during a Regional Health meeting for Africa with National Societies and IFRC offices in Africa.

A list of contributors to the guidelines is appended (Annex 1).

Understanding concepts and definitions

CARE IN COMMUNITIES

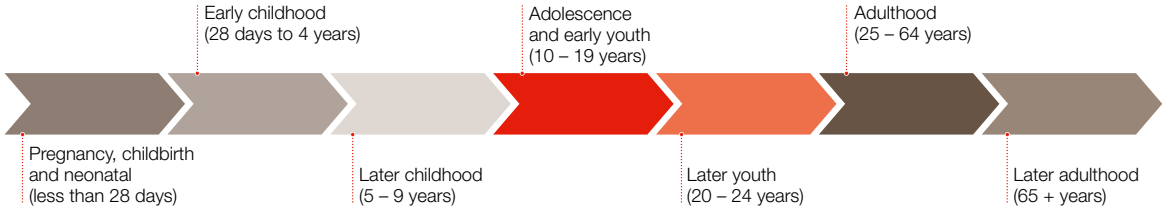
Care in Communities is defined as health-related actions carried out by CBHWs (including trained Red Cross Red Crescent volunteers) related to primary, secondary and tertiary prevention in varied settings. At the community level, CBHWs deliver evidence-based, essential interventions throughout people's life course.

Primary prevention involves actions taken prior to the onset of disease, which make it less likely that a disease will ever occur. These actions include generalized measures to promote good health and specific protective interventions such as health education, immunization, use of bed nets, handwashing, etc. Secondary prevention means actions which halt the progress of the disease at its incipient stage and prevent complications. These actions include early diagnosis and treatment. Examples of secondary prevention at the community level are Integrated Community Case Management (iCCM), screening for diabetes and high blood pressure, and case finding of neglected tropical diseases (NTDs). Tertiary prevention measures reduce or limit impairments and disabilities, minimize suffering caused by existing departures from good health and promote the patient's adjustment to irremediable conditions. These measures can include the management and rehabilitation of community members through the care and support of older persons, home care of individuals with HIV and pain management of cancer patients.

LIFE COURSE APPROACH

The life course approach states that each stage of an individual's life – from infancy to old age – influences the next stage. The social, economic and physical settings where an individual works, lives and plays across their life course has a huge impact on their health and the health of those around them. As per WHO, the life course approach is a holistic way to optimize people's health and well-being throughout life and interlinks with human capital and sustainable development. Almost 70 per cent of NCDs and mental illnesses in later life are associated with exposures to risks and inequities in earlier years[14,15]. The benefits and returns of the life course approach to health is 10 times more with increased effectiveness, efficiency and equity[16].

Figure 1: Life course approach

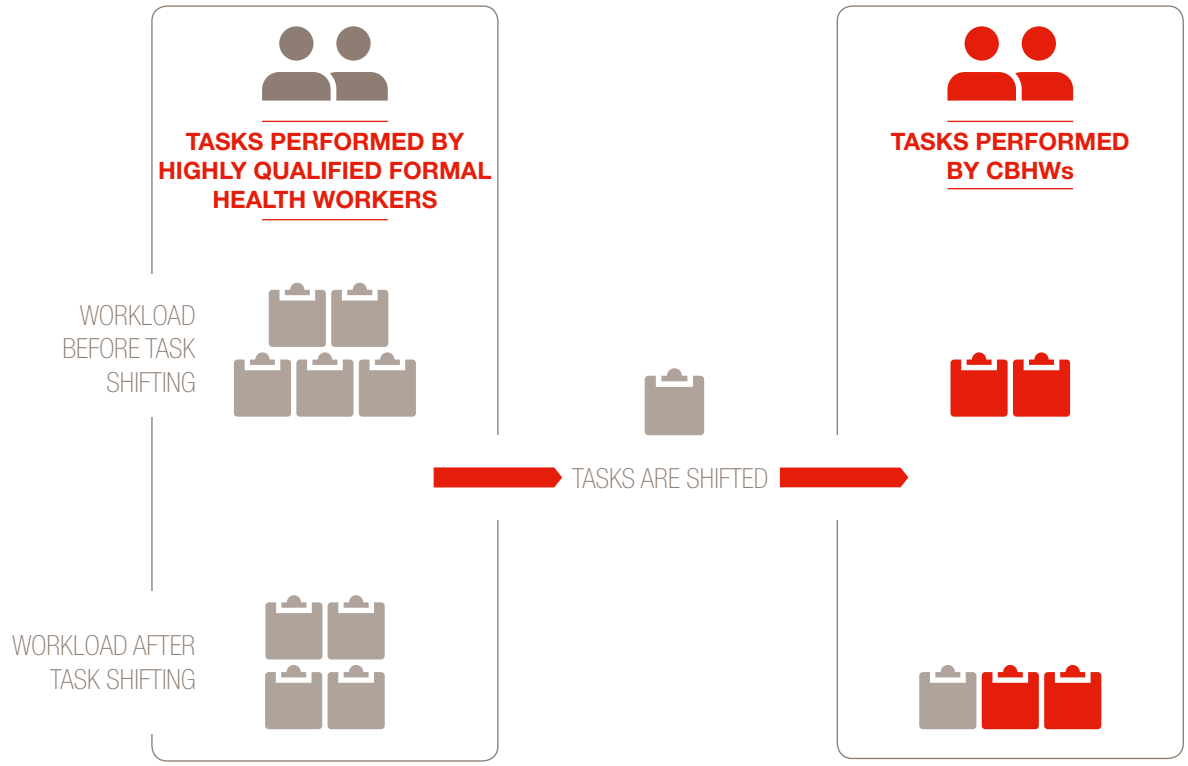


TASK SHIFTING

Task shifting involves the rational redistribution of tasks among health workforce teams. According to WHO, task shifting "presents a viable solution for improving healthcare coverage by making more efficient use of the human resources already available and by quickly increasing capacity while training and retention programmes are expanded"[17]. Specific tasks are delegated, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications[17,18].

Task shifting includes various scenarios, such as substituting tasks among professionals, delegating tasks to professionals with less training (including creating a new cadre), delegating tasks to non-professionals, or a combination of these[19]. Task shifting can produce equivalent or superior outcomes for NCDs, HIV/AIDS and contraceptive distribution[7,20,21].

Figure 2: Task shifting – tasks are moved, where appropriate, from highly qualified formal health workers to CBHWs with shorter training and fewer qualifications



TASK SHARING/ROLE DELEGATION

The term "task sharing" is often used synonymously with task shifting in the literature. However, task sharing is a situation where the levels of health providers are expanded to deliver health services appropriately[22]. Tasks are not taken or shifted from one cadre of health worker to another. Rather, additional cadres are engaged to deliver the identified tasks. Mid- and frontline levels of healthcare professionals such as nurses, midwives and CBHWs are given the responsibility to carry out clinical tasks and procedures that would otherwise be carried out by higher-level professionals. It is an effective and efficient strategy in situations where there is a shortage of higher cadres of healthcare workers. Task sharing increases availability and access to family planning services, frees up the time of higher-level cadres for other specialized tasks and reduces costs while providing more efficient health and care services in a less clinical or medical setting[22].

COMMUNITY-BASED HEALTH WORKERS

WHO defines community-based health workers as "health workers based in communities (i.e. conducting outreach beyond primary health care facilities or based in peripheral health posts that are not staffed by doctors or nurses), who are either paid or volunteer, who are not professionals, and who have fewer than two years training but at least some training, if only for a few hours"[23]. For these guidelines, both Red Cross Red Crescent volunteers and CBHWs fall under this definition.

Red Cross Red Crescent network volunteers are vital in providing a frontline response when emergencies strike, as well as in the context of longer-term activities aimed at improving the health of communities. Within the Red Cross Red Crescent network, volunteers work in different roles across a spectrum from pure unpaid "volunteerism" to paid CBHWs. In all scenarios, CBHWs create a bridge between their communities and their local health systems.

CBHWs "come from within the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organization, and have shorter training than professional workers"[24]. CBHWs may be polyvalent, carrying out a variety of roles at community level and delivering multiple primary care interventions[12].

National Societies in different countries may call their CBHWs by other names. Some examples are given in Box 1 below.

Box 1 Nomenclature for CBHWs (including trained Red Cross Red Crescent volunteers) by National Societies

Kyrgyzstan: Volunteers (community leaders), TB case promoters

Burundi: Community health volunteers

Kenya: Community health volunteers/Community health workers

South Sudan: Home health promoters/providers (as per the government terminology)

Role of IFRC

The IFRC has a unique advantage among relief, development and humanitarian international organizations in advocating, planning and implementing an approach to CIC programming based on care and support, task shifting/sharing and role delegation. The IFRC network has committed to making the "last mile" its collective "first mile" and has access to underserved and marginalized populations through Red Cross Red Crescent volunteers. IFRC, with its member National Societies, has significant experience in meeting the needs of vulnerable communities during emergencies (e.g. natural disasters, population displacement), due to its presence in communities as a neutral, impartial, and independent community-level actor.

The role of IFRC can be categorized under three key strategic themes:

1. Support National Societies in the delivery of evidence-based, impact-driven, effective, appropriate and context-driven community-based interventions across the continuum of care from relief to recovery in humanitarian and development contexts in low-, middle- and high-income countries.

Specifically:

- Development of a comprehensive strategy and operational framework/guidelines for National Societies for programme development and implementation
- Development of essential community health services packages for National Societies
- Expand the spectrum, quality and scale of National Society community health programming
- Work with National Societies to link more strongly with governments
- Build capacity of National Society staff and CBHWs to strengthen other cadres of health workers involved in primary health care and by so doing, enhance programme components

Depending on the National Society in terms of capacity, funding, human resource (HR) capabilities and programmatic focus and the local context in terms of the government's health policy and national guidelines, priority health needs of communities, especially vulnerable communities, gaps within the health system, and the context (whether developmental, emergency or humanitarian), this menu of tools can be taken up and implemented as needed by National Societies.

2. Develop mechanisms to capture evidence and good practices and measure impact in emergency, non-emergency and humanitarian settings to promote accountability for resources and results.

Specifically:

- Development of a platform to enable continuous and frequent mapping of the Red Cross Red Crescent CIC programmes, lessons learnt, challenges and outcomes
- Development of uniform monitoring and evaluation (M&E) tools and building monitoring, evaluation and reporting capacity among National Societies to highlight the contribution of the Red Cross Red Crescent network to the national and global goals

As auxiliaries to public authorities, National Societies have been supporting the formal health systems in various countries using community health approaches like task shifting/sharing, harm reduction, home-based care of older persons and HIV care in the community. These programmes have, however, often been developed in isolation in each country as different National Societies responded to needs and built partnerships with formal health systems. As of now, comparisons cannot be made between countries carrying out similar programmes as the indicators, M&E structures, training and coordination mechanisms with formal health systems are non-standardized. It is important to identify best practices and develop common objectively verifiable key basic indicators, suggested M&E structures, training manuals/programmes that can be adapted to local context, guidelines for partnering with formal health systems, examples of successful CIC programmes and support to help create networks of National Societies who are carrying out similar CIC programming.

IFRC will be able to record the cumulative CIC experience and conduct continuous and frequent mapping and evaluation of the programmes conducted across the regions. The analyses are to be used to help steer future programmes.

3. Advocacy, positioning and partnership development of National Societies with respective national health authorities to increase the Movement's role at the global, regional and national level.

Specifically:

- Develop shared leadership, partnerships and coordination, and exchange programmes among National Red Cross and Red Crescent Societies
- Resource mobilization in terms of technical (HR) and programme funding
- Assist in communication efforts regarding the role of CBHWs globally and nationally
- Development/adaptation of tools to support the National Society's approach to authorities to recognize and enhance its auxiliary role in health, including good practice, data and examples of National Society engagement in national health agendas, policies and discussions
- Capacity building of National Societies to build strategic relationships with governments and other key stakeholders that would facilitate their understanding of the benefits of task shifting by CBHWs

Resource mobilization: Supporting National Societies to leverage funding for new programmes that optimize resources to provide care at the community level. Focusing on CIC will create new opportunities for funding in different areas and likely create more sustainable sources of funding from within countries through partnerships with governments.

Raising awareness to advocate inside the Red Cross Red Crescent Movement about CIC, task shifting/sharing and role delegation and optimal usage of resources within health systems and at the community level is an important task in the coming years.

Development of advocacy tools is an important task to support National Societies to better position CIC in their respective countries in order to take the lead and strengthen the auxiliary status with public authorities.

Role of National Societies and cooperation mechanisms with the health authorities

As community-based humanitarian organizations and auxiliaries to the public authorities, National Societies are well-positioned to strengthen the link between marginalized and vulnerable communities and the formal health system through their CBHWs in diverse settings.

The National Societies are in a unique position to support CIC programmes in close collaboration with health authorities, communities and health systems and to train and empower volunteers and CBHWs to confront health-related challenges. These interventions need to be context-specific and linked with the formal healthcare system and must be supported by facility-based services.

National Societies have national level legislations and written agreements with governments for their existing programmes. As CIC programmes develop, more specific agreements will need to be created. The agreement or Memorandum of Understanding (MoU) should include the objectives of the programme, duration of the programme, terms of agreement and governing terms, roles and responsibilities of the National Society and the government, geographical areas, services provided, financial management and budgets, supportive supervision, monitoring and evaluation, supply chain and logistics for medicines and/or diagnostic tests to be provided by the government, and where possible, the long-term plan for the programme and identification of responsibilities to ensure sustainability.

These arrangements should reflect applicable regulatory and legislative frameworks in the jurisdiction. The precise terminology may need adaptation, considering that the term "MoU" entails specific obligations in some contexts that could inadvertently hinder or deter the institutionalization of the programme.

In protracted crisis settings, countries may not have a stable government with which the National Society can engage and it may be necessary to implement the CIC programme directly with other actors.

In countries where National Societies are already implementing CIC programmes, the National Society and the national government could create a wider written agreement to outline their commitment to improving human resources for health which identifies the Red Cross Red Crescent as a key partner in implementing CIC programmes, outlining the role of each party and shared goals.

Some of the other roles that are envisaged to be taken up by National Societies in the field of CIC include:

- Analysis of the current national policies and practices related to the status of CBHWs, including their selection, training, supervision, incentives and effective linkage to the health system in collaboration with the health authorities.
- Development of a country action plan for CIC that is evidence-based and can be effectively delivered by CBHWs in collaboration with the MoH and other stakeholders in accordance with the government's national health plans and policies.
- Identification and addressing of gaps in the coverage of health services at community levels. This should include feasibility, costs and sustainability of these services, and the potential role and financial implications of CBHWs in increasing access to preventive, promotive and curative health services.

- Identification of interventions and competencies related to the health SDGs that are most relevant to that setting. Training curricula should be evidence-based and cover promotive, preventive and curative health care in relation to the identified interventions.
- Use of creative and innovative approaches that would contribute to better health outcomes.
- Development of mechanisms to ensure the provision of regular supportive supervision to CBHWs in partnership with the MoH.
- Establish age- and sex-disaggregated indicators to monitor the performance of CBHWs and programmes in general, and conduct ongoing M&E using these.

Selection criteria of CBHWs, including volunteers

Effective recruitment and selection can improve the performance of CBHWs and the quality of services delivered. Selection of volunteers should follow the National Society's volunteering selection and recruitment policies. It is important to identify the government criteria for selection and recruitment of CBHWs and as far as possible, the recruitment needs to be aligned with the formal health systems. Since National Societies have an existing pool of trained volunteers, selection of CBHWs can be done from this group as per the planned interventions.

It is suggested that the following criteria be used for selecting CBHWs including trained volunteers:

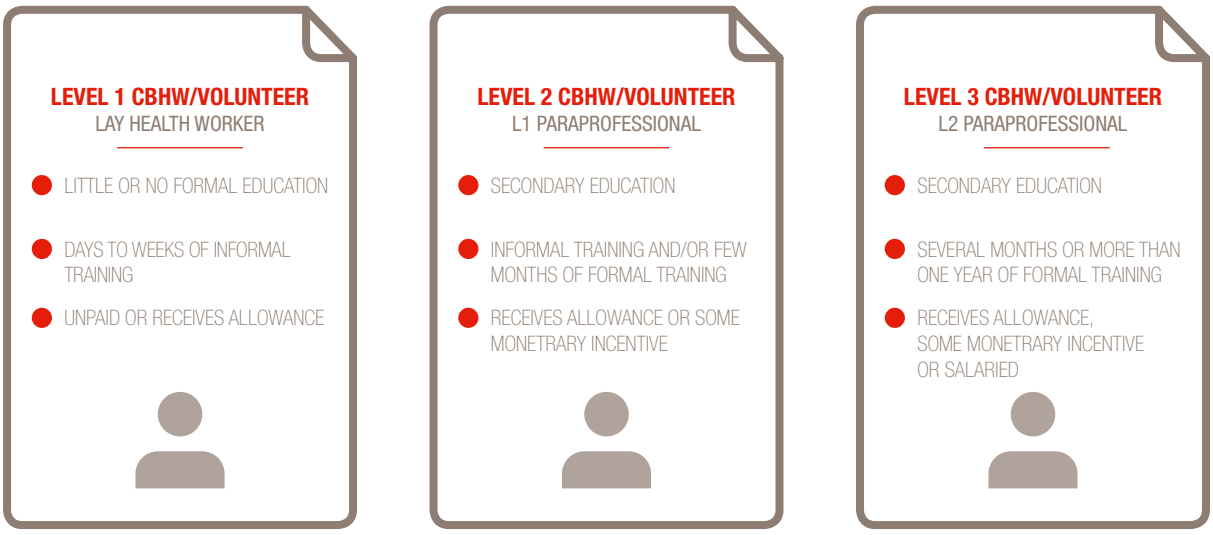
- The CBHWs should be selected based on the minimum educational qualification that is deemed necessary for the tasks to be carried out. This will vary from country to country and context (protracted/developmental). Where possible, this should be aligned with the government's criteria. Since the CBHWs will be expected to report and keep records, it will be helpful to have primary level education at least. In high-income countries, educational level will be higher. The candidates should undergo a literacy and competency test to see if they are suitable for the work.

  If helpful, one of the propositions for National Societies is to categorize CBHWs as follows[24]:

  1. **Level 1 volunteers or community health workers - lay health workers** (individuals with little or no formal education who undergo a few days to a few weeks of informal training).
  2. **Level 2 volunteers or community health workers – L1 paraprofessionals** (individuals with some form of secondary education and subsequent informal training and/or few months of formal training).
  3. **Level 3 volunteers or community health workers - L2 paraprofessionals** (individuals with some form of secondary education and subsequent formal training lasting a few months to more than a year).

  Lay health workers tend to provide basic health services as unpaid volunteers or may receive an allowance while level 1 paraprofessionals often receive some allowance, or a monetary incentive, and level 2 paraprofessionals tend to be salaried.

Figure 3: Proposed method of categorizing CBHWs by National Societies



- Residence: the candidate should belong to the target community and reside there.
- Gender equity appropriate to the context (considering affirmative action to preferentially select women to empower them and, where culturally relevant, to ensure acceptability of services by the population or target group); some examples are Female Community Health Volunteers in Nepal, Shasthya Shebika in Bangladesh, Kaders in Indonesia [25,26,27].
- Personal attributes such as trustworthiness, respect, kindness and empathy, interpersonal skills, capacities, previous experience of the candidates[28].
- The candidate should speak the local language.
- Recruitment needs to be done with active community involvement and community acceptance. It is important to involve the entire community, where possible, and not just the community leaders. At times, involving only the community leaders can lead to a "biased" representation.
- It may be a good idea to select more candidates than required for pre-service training accounting for dropouts, especially in the first month.

Contracts: CBHWs should be guided as per National Society policies. However, a clear job description should be agreed, specifying role and responsibilities, working conditions and incentives. The contract should stipulate the number of hours per week that the CBHWs will be conducting CIC activities. Increase in responsibilities of CBHWs as they go up the career ladder should be guided by the National Society policy and contract provisions.

Target population size

To maintain a realistic workload, instil accountability and optimize the performance of CBHWs, a target population size should be assigned. This should be done as per National Society policy and formal health system recommendations. The CBHW:population size ratio will depend on several factors such as:

- The size and density of the population
- Target population type – mobile population etc.
- The topography and geography – the difficulty of terrain/availability of transport
- Expected workload based on epidemiology and anticipated demand for services

- Frequency of contact required
- Availability and weekly time commitment of CBHWs (factoring in time away from service provision for training, administrative duties and other requirements)
- Safety and security situation

Below are selection criteria used by some National Red Cross Red Crescent Societies in their existing CIC programmes which can serve as a guide for other National Societies planning similar programmes (Box 2).

Box 2 Selection criteria for CBHWs used by some National Red Cross Red Crescent Societies in their existing CIC programmes

South Sudan Red Crescent Society: Home health providers (HHPs) are selected by the local community (village) using the following criteria (aligned with the Government criteria):

- Permanent resident of the community; accepted by the community
- Women highly encouraged (at least one per team must be a woman)
- Must speak the local language/dialect of the community
- Literate and have numeric skills for reporting, training and meetings (desirable)
- Have the commitment to serve the community as HHP on a voluntary basis
- CBHWs:population ratio: one HHP per 30—40 households in densely populated areas (urban) or two HHPs (one woman and one man per village) in sparsely populated areas (rural)

Kenya Red Cross Society: CBHWs are selected based on the following criteria:

- Basic reading and writing skills; good understanding
- Good standing in the community
- CBHW: population ratio: one CBHW per 50—100 households; they have to visit each household twice every month.

Myanmar Red Cross Society: CBHWs are selected for the project based on:

- Volunteer experience (at least one year)
- Commitment to stay and work at the assigned village for at least three years after training
- Should have a middle standards education

Kyrgyzstan Red Crescent Society:

- CBHW: population ratio: Each volunteer has to cover 200 households per year and each household has to be visited at least three to four times/year.

Training and competencies

Successful CIC programmes require CBHWs who have received effective and comprehensive training. CBHWs should receive intensive training at the initiation of the programme and ongoing training throughout the course of the programme. Regular refresher training at set intervals will help sustain and strengthen acquired knowledge and competencies of CBHWs. Ongoing training can be carried out online where such facilities are available. In programmes where CBHWs have more or complex tasks, phased training of thematic interventions/services to facilitate uptake and appropriation by CBHWs can be carried out.

Presently, the trainings are not standardized, with duration of training ranging from a few hours to several months. The guidelines suggest the following criteria for determining the duration and curriculum of training[12]:

- Scope of work and interventions
- Roles and responsibilities
- Competencies required to ensure high quality service delivery: the more polyvalent the role of the CBHWs, the longer the training will be
- Pre-existing knowledge and skills (whether acquired through prior training or relevant experience)
- Social, economic and geographic circumstances of trainees and work environment
- National Society capacity to provide the training

Training should be modular, participatory, interactive, hands-on and follow adult learning methodology. Where possible, the training should occur within the community or as close to the community as possible. The practical part of training should take place in the community whereas the theoretical part can take place either in the branch office or the health facility closest to the community and as per the protocol of the MoH.

It is recommended that a certificate of training be provided by the National Society to the trainees who have successfully completed the training. National Societies should ensure that these training certificates are recognized and acknowledged by the government and this matter should be included in the MoU.

Duration of training provided by some National Societies for their CIC programmes is provided below (Box 3).

Box 3 Duration of training

Kenya Red Cross Society: five days each for iCCM and NCDs

Myanmar Red Cross Society: one month for maternal, newborn and child health

Incentives

Incentives, both monetary and non-monetary, are important motivating factors for health workers[29]. CBHWs usually receive a mix of financial and non-financial incentives from the government/organization and the community. While financial incentives are very important, they have to be backed up by non-financial incentives to motivate CBHWs[29].

Financial incentives are in the form of salary/stipend/allowance/per diem or payments linked to performance. Non-financial incentives provided by the community include community recognition, positive changes in health behaviour, and faith and responsibility placed in CBHWs by the community[30,31,32]. The government/organization also contributes through worker recognition (uniforms, certificates, badges), opportunities for career advancement, supportive supervision, ongoing structured training and performance reviews[32,33,34]. Clearly defined tasks and manageable workloads increase the job satisfaction of CBHWs. Regular contact with the rest of the health system increases respect for and the success of CBHW programmes[9]. It is important to note that lack of monetary incentives is associated with frequent loss of volunteers, especially when their responsibilities are being enhanced[35].

Consistent and predictable incentives that CBHWs regard as appropriate to their tasks and level of training are recommended[36]. For health workers expected to work 20—40 hours/week, it is recommended that they be compensated in some way for their work as there is little evidence otherwise that volunteerism is sustainable for long[8].

Except for small financial incentives, Red Cross Red Crescent volunteers are not usually remunerated monetarily for their work. Non-monetary incentives such as public recognition, training opportunities and material goods are provided in various Red Cross Red Crescent projects and programmes to motivate volunteers. Research on Red Cross volunteers working as CBHWs in Ethiopia identified prompt material incentives, monthly financial incentives and provision of regular feedback in a constructive manner to be important motivating factors[37].

Incentives for CBHWs differ by National Society and a uniform blanket approach would be difficult to propose. A mix of financial and non-financial remuneration is recommended for the CIC programme. Non-financial incentives such as community recognition, training, certificate of training recognized/acknowledged by MoH, supportive supervision, career advancement opportunities and provision of items (such as caps, badges, backpacks) are recommended. It is also recommended that National Societies in LMICs follow the government's system of CBHW remuneration, where such systems exist. This should be commensurate with the role, hours of work per week and capacity of CBHWs. It may be in the form of a minimum wage or allowance. In addition, all CBHWs should be compensated for expenses incurred while delivering services.

It is recommended that remuneration be based upon the different levels/tiers of Red Cross Red Crescent volunteers and CBHWs as proposed under the selection criteria (Levels 1, 2 and 3 of CBHWs). This tiered system will include the first level of Red Cross Red Crescent volunteers with some basic health training who volunteer for a few hours/week, a second tier of more specialized volunteers trained in one or more areas of CIC who spend a longer time in the community per week (10—15 hours per week or as per the National Society volunteer policy), and a third tier for those who are even more specialized including midwives, nurses and medical assistants. The incentives (monetary or otherwise) for each tier should increase by level of specialization and include payment for the higher tiers. These tiers or levels will act as a career ladder for Red Cross Red Crescent volunteers and would provide them further incentive to remain with the Movement.

Financial incentives can affect CBHWs' performance and sustainability of programmes when discontinued or irregularly provided and it is recommended that such remuneration be channelled through the government to the National Society to pass on to CBHWs. This should be clearly mentioned in the MoU between the MoH and the National Society.

Some examples of incentives provided by various National Societies for task shifting programmes are provided here for an understanding of current practices (Box 4).

Box 4 Examples of CBHW incentives provided by some Red Cross Red Crescent National Societies

South Sudan Red Cross: a monthly stipend of 750 South Sudanese Pounds (5.7 CHF), continuous capacity building, awards, and recognition as opportunities are provided.

Kenya Red Cross: a monthly stipend of 2,000 Kenyan Shillings (19 CHF), income generation activities and medical insurance for all CBHWs, trainings, backpacks, equipment and supportive supervision is provided.

Liberian National Red Cross Society: quarterly stipends of approximately CHF 50 and rice, oil, bouillon cubes are provided, as recommended by the national protocol.

Supportive supervision

Supportive supervision is a critical factor in maintaining CBHWs' motivation and the quality of the programme[23,30]. It is evident that regular and systematic supervision along with clearly defined objectives lead to improved performance of CBHWs involved in primary healthcare services[38,39]. Supervisors may have a clinical or non-clinical background depending on the level of volunteer and identified tasks: nevertheless they need to have sound technical knowledge with appropriate training. Since the CIC programmes will be integrated with the government agencies, the supervision should be done jointly by staff from the primary healthcare facility and the National Society. **These guidelines recommend regular supervision (at least once a month) for effective CBHW functioning.**

The following approaches are recommended for supportive supervision:

- Under ideal conditions, supervisors should be from the Red Cross or Red Crescent branch office.
- Supervisors should be trained on necessary skills (facilitation, interpersonal communication, problem solving and analytical skills) in close coordination with the MoH, oriented to various tools and methods (peer review and performance assessment tools) and provided with frequent opportunities to upgrade their technical skills.
- Appropriate supervisor–CBHW ratio: depending upon the capacity, terrain and context, the supervisor-CBHW ratio should be such that the supervisor is able to conduct monthly visits at least. Review of all activities should be carried out regularly and a minimum of once-a-month review using supervisory tools, such as task checklists, is recommended alongside qualitative monitoring, coaching, mentoring and interpersonal engagement.

- Home visit/community feedback: visits to the community to conduct random checks of CBHWs' activities and obtain feedback on CBHWs' actions from clients are recommended.
- Supervisors need to be a part of, or be linked to, the government system. They should use the same tools and checklists to adhere to quality standards.
- Peer support and supervision by senior, experienced CBHWs should be considered.

Burundi Red Cross has a focal point who is paid and works in collaboration with the MoH to supervise the CBHWs.

Measuring the change: reporting, monitoring and evaluation

While data collection by CBHWs can serve a variety of purposes – for example, surveillance or research – a key objective is an improvement in service delivery and CBHWs' performance itself. Data on CBHW performance as well as programme indicators need to be built into a simplified Health Management Information System (HMIS). Indicators for reporting should be decided by the National Society in conjunction with the government health authorities.
Programme indicators that are specific, measurable, achievable, relevant and time-bound (SMART criteria) and allow measurement of results at all levels (input, output, outcomes and impact) should be used. The indicators represent the continuum of care and each one relates to other dimensions of health and health systems. For example, antenatal care coverage measures access to the health system and its ability to identify maternal risks and improve health outcomes for the mother and newborn.

Data, while being collected more frequently from the health system (home visit forms, review of health records, supervisor observations), should also include community feedback (from community leaders, clients and community groups like village health committees) and CBHW feedback on performance – their own as well as programme feedback. Other types of data such as the availability and supply of materials, tools and technology can also be incorporated.

Regular reports from the CBHWs should be collected by the supervisors at least on a monthly basis. Reporting may be done on paper, Excel sheets or through mobile technology (mHealth). The data, if on paper forms, will be checked by the supervisors and then collated at the supervisor, branch and country office level. The supervisors will use the data to ensure the CBHWs are meeting their targets while at the National Society level, the data will be used to make changes to the programme, if required. Data sharing with the MoH should be clearly outlined in the MoU.

It is essential to introduce a results-based management approach to all phases of the programme. It is recommended to develop a Planning, Monitoring, Evaluation and Reporting (PMER) toolkit which would help National Societies consolidate CIC programmes and also contribute to information sharing at the global level.

The data generated should be used to:

- Monitor, adjust and identify programme requirements (for example, stock-outs, epidemiological trends, human resource and financial needs) so that the service meets the needs of recipients.
- Engage communities in finding local solutions to identified problems.
- Supervise and support CBHWs to build their knowledge, competencies and skills for the benefit of service recipients.
- Allocate resources for conducting base, mid and end-line surveys and for data compilation and analysis for better and informed implementation at community level.
- Develop standardized, uniform and simple planning, monitoring, evaluation and reporting tools to be adapted and used at the community level to ensure high quality of implementation.
- Plan for the continuous review and update of M&E throughout the programme.

Supply chain mechanisms

Consistent availability of affordable essential drugs, diagnostic tools and technologies is crucial to the success of CIC programmes. Supply chain bottlenecks not only affect the programme and reputation of National Societies but also place vulnerable client populations at further risk.

To ensure the continuous and uninterrupted supply of commodities, supply chain mechanisms must be clearly outlined in the MoU between the National Society and the MoH and should be included in the national pharmaceutical supply plan or its equivalent. It has been recommended by Red Cross Red Crescent personnel that the supply chain be managed by the MoH. Mechanisms to replenish the equipment and supplies required by CBHWs vary, but national distribution systems of commodities should address the needs of CBHWs on the ground based on reliable data and forecasting. One model for the supply chain would be to link it to the primary healthcare facility from where the supply would be disbursed to CBHWs via the supervisors on a monthly basis.

Availability of mHealth to support different supply chain functions: Simplified stock management tools and visual job aids for CBHWs with minimum data points are instrumental to facilitate recording of data, adequate storage (including keeping perishable supplies at the right temperature), mapping and monitoring for early warning.

Community engagement and accountability

Community engagement and accountability (CEA) is an approach to Red Cross Red Crescent programming and operations that puts communities at the centre of all the Movement's programmes. CEA involves providing timely, relevant and actionable, lifesaving and life-enhancing information to communities whilst using the most appropriate communication approaches to listen to communities' needs and feedback, ensuring they can actively participate and guide Red Cross Red Crescent actions. Adopting a more systematic approach to CEA contributes to improved accountability to communities, builds acceptance and trust and supports sustainable programme outcomes.

The IFRC/ICRC CEA Toolkit and the eCBHFA module 2 describe various community engagement approaches used by National Societies and these strategies can be adapted for CIC. Some of these approaches are:

- Community consultation before the intervention to identify programme goals and objectives.
- Sensitizing community members, leaders and other key stakeholders.
- CBHW selection and recruitment in close consultation with community members. Community support will be enhanced be having a "thoughtful entry process" by conducting a meeting(s) where the CBHWs are introduced, their role defined, and a connection is made to the National Society and formal health system[40].
- Community health committee formation with regular meetings for programme oversight at community level.
- Implementation and assessments with community involvement.
- Engaging community members in providing incentives and retaining CBHWs.
- Sharing outcomes with community members.

Ensuring quality of care in communities

Quality of care depends on a combination of the following:

Selecting qualified and willing volunteers and CBHWs with appropriate qualifications to take on new skills (for example the volunteers must be able to read to take on certain skills, or the government might require a certain level of education).

Appropriate initial and ongoing training for CBHWs.

Supportive supervision of volunteers and CBHWs is key to keeping up motivation and ensuring quality of care. As per existing practice, the involvement of the local health system in volunteer and CBHW supervision may not be the norm for some National Societies and local branches. For sustainability, it is recommended that supervision be carried out in partnership with local health system personnel whenever possible.

A functioning referral programme.

Improving M&E. The outcomes of CIC programmes need to be documented, reported and disseminated to ensure successful implementation of activities and to steer policy decisions.

Introducing innovative approaches to the efficient delivery of health services.

- **Cash transfer programming: This is being increasingly used in humanitarian response and** helps remove financial barriers to health services.
- **mHealth, information and communication technologies** have a huge potential for bridging the gap between health providers and those in need of services, and in supporting health information systems and health infrastructure. Many National Societies have been utilizing mHealth or technology to support projects: for example, use of RAMP/MAGPI, Open Data Kit (ODK) and other tools for malaria, Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH), and Typhoon Haiyan recovery operation etc.

Risks and challenges

While a discussion on all possible risks and challenges to CIC programming is beyond the scope of this document, an effort has been made to identify and address the most relevant ones throughout the document as per the experience of IFRC/National Societies.

There is a threat of overburdening volunteers and CBHWs by enhancing their roles and responsibilities. Some ways to circumvent this are by adding more CBHWs, developing more specialized cadres of CBHWs or modifying roles of CBHWs in accordance with changes in overall health burden. The CIC programme is an option that National Societies can choose to implement based on current needs and capabilities. This goes with the principle of optimal utilization of resources and capacities.

There are ethical issues involved in transferring the responsibility of providing diagnostic and curative health care services to CBHWs who have not received as much training as auxiliaries, nurses or physicians. CBHWs should not be performing certain tasks as independent practitioners without clinical oversight and regular quality assessment. Government regulation of CBHW activities must ensure that CBHWs conducting these services are appropriately trained and supervised. It is the responsibility of governments, with the input of clinical regulatory and health professional bodies, to establish national guidelines and regulations under which CBHW programmes operate.

Some of the other risks and challenges that are to be kept in mind when designing the programme are:

- Shortages of basic drugs and irregular supply of vaccines and commodities (e.g. contraceptives)
- Inadequate and irregular supervision
- Lack of equipment and non-functional equipment
- Insufficient initial and continuing training
- Low status and remuneration can be an issue in some National Societies
- Inadequate linkages with health system

Ensuring sustainability and analysing conditions for a win-win situation

Sustainability of National Society programmes and projects depends to a large extent on identifying longer term funding sources. The MoU needs to identify mechanisms to continue the programme beyond the end-date such as co-funding, stepwise phased out funding by the Red Cross Red Crescent and exploring other options for funding and partners.

In some countries, the government has recognized the success of National Society activities and has taken on their funding (for example the TB programme in India and the malaria programme in Myanmar). Having the government directly fund National Societies to carry out CIC activities will ensure sustainability and demonstrate a win-win situation for all parties. At times, governments are not in a position to fund Red Cross Red Crescent projects, having limited funds for health to begin with. In such circumstances, the activities of CIC projects can become integrated into the health system itself and be directly funded by the health system.

Since CIC programmes provide care at the community level, they require strong coordination and collaboration with the health system to supply CBHWs with medical supplies, for the health system to receive referrals, and for CBHWs to receive follow-up training, supervision and/or monetary incentives.

Recognizing the costs of and budgeting for CIC activities like supportive supervision, M&E, personnel and time spent on visits to community and to coordinate with government partners are also important to sustainability.

Recommendations to operationalize the guidelines

These guidelines are not prescriptive and should be seen as a critical overview of evidence and a menu of inter-related options and recommendations, which, nevertheless, need to be adapted to the reality of each country and setting. CBHWs should be regarded as an important element of primary healthcare teams and not as cheap or free labour.

Key elements and guiding principles

Service delivery is the sum output of all the inputs into a health system (health workers, funding, equipment, facilities, etc.). Some of the key elements and guiding principles of health service delivery that the National Societies should consider for planning and implementation of CIC programmes are[41]:

- Life course approach: this approach takes a temporal and societal perspective on the health and well-being of individuals and communities. It involves taking appropriate action early in the life course and during life's transitions.
- Comprehensiveness: promotive, preventive, curative, palliative and rehabilitative health care services should be provided to the community, as per its needs.
- Accessibility: health services are easily accessible to all community members at primary care level. Services may be provided in the home, the community, the workplace or the health facility, as appropriate.
- Coverage: all community members, irrespective of their personal or health attributes, should get health services in all contexts and settings.
- Continuum of care: community members should have continuity of care across the network of services, health conditions, levels of care and over the life cycle.
- Quality: health services should be of high quality. They should be effective, safe, timely and focused on a patient's need.
- Coordination: local health service networks should be well coordinated across types of provider, types of care and levels of service delivery, for routine as well as emergency situations.
- Accountability and efficiency: health services should be well managed to avoid wastage of resources. Managers should have the authority to achieve planned objectives and be accountable for performance and results.

National Societies and their programme managers should consider these when developing CIC programmes:

- Engage with the MoH, local authorities and all potential stakeholders with MoUs specifying roles and responsibilities.
- Community engagement, sensitization and mobilization.
- Recruit volunteers and CBHWs according to appropriate selection criteria.
- Involve the community and CBHWs in the planning and implementation process.
- Conduct a situational analysis of the community and health systems to identify capacities, gaps and challenges.
- Examine gender and power dynamics roles/relationships in the targeted communities and address identified problems.
- Identify critical gaps in the continuum of care, analyse barriers to access and use of essential interventions.
- Develop an appropriate and realistic scope of work that addresses the priority health service gaps and a strong perceived need felt by both the government and communities; identify interventions in close coordination with local authorities and communities.
- Frame the role of volunteers and CBHWs vis-à-vis other formal health workers to integrate into the general health system.
- Adapt training content to local needs, use appropriate training methodologies, and evaluate and improve the materials.
- Ensure continuous capacity development for CBHWs through initial training followed by ongoing training, refresher courses and regular supportive supervision.
- Develop supportive supervision mechanisms.
- Secure equipment, supplies and intervention packages as per MoH protocols.
- Motivate CBHWs using non-financial and financial incentives.
- Establish effective linkages for referral to and counter-referral from other health services.
- Establish indicators to monitor and track performance of CBHWs and the programme.
- Define performance indicators and conduct periodic programme performance evaluation and quality improvement processes to ensure quality standards in CBHW training and programme implementation.

Part 2A:
Essential evidence-based health services packages for delivery at the community/ home levels

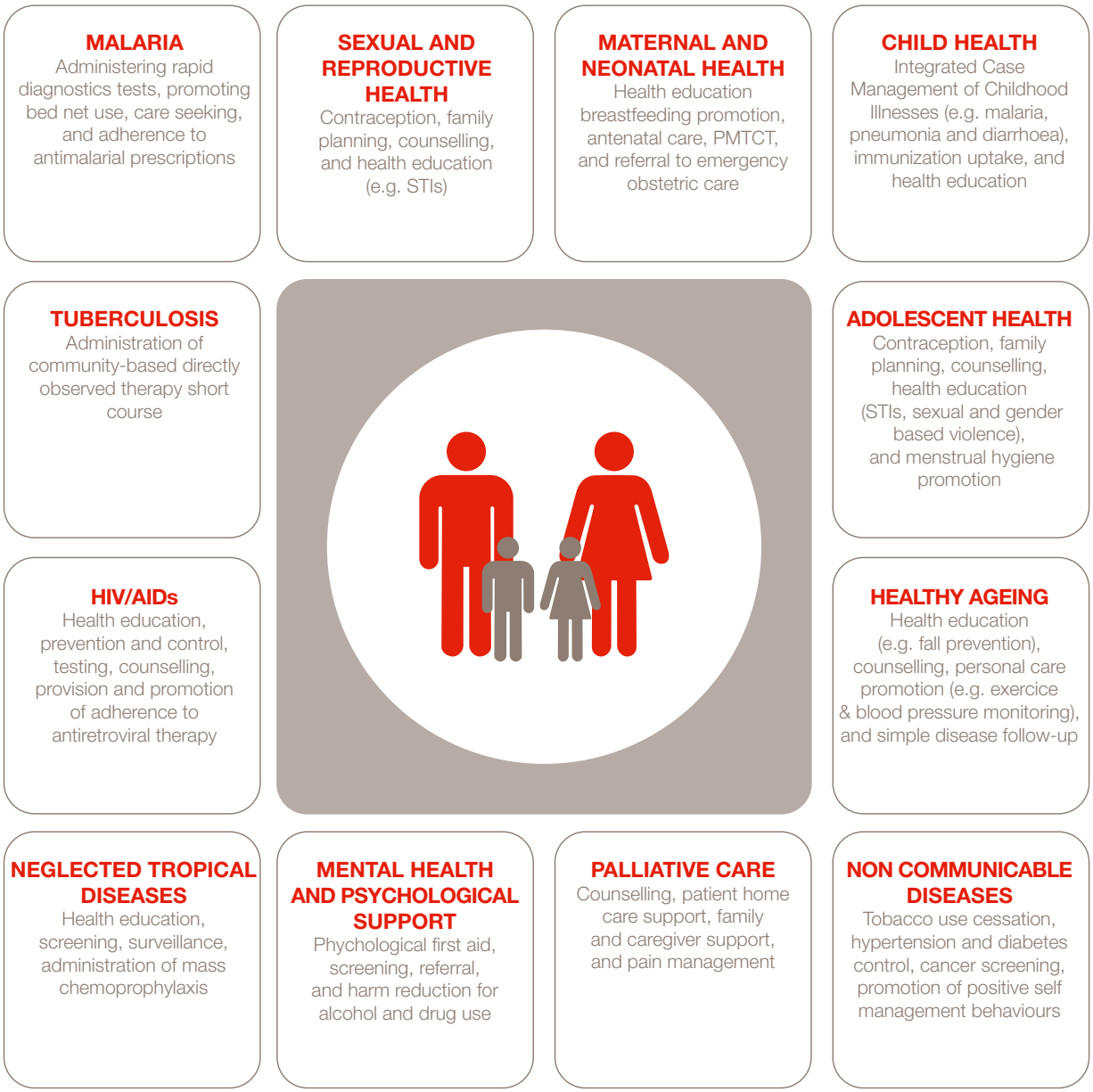
Service delivery can be organized in many ways depending on the task and the community characteristics such as rural/urban/mobile population. Clinical services can be delivered at the primary health outpost, whereas antenatal care, family planning services and immunizations can be also delivered via scheduled outreach programmes. Door-to-door visits can also be done for some services such as provision of preventive health commodities like contraceptives and simple medicines like Oral Rehydration Solution (ORS), zinc etc. Health education can be carried out one-to-one at the clinic or community level or through public gatherings.

The approach to CIC in emergency settings would be to recognize the link between development settings and preparedness, relief and recovery transitioning. Leaving no one behind and reaching the last mile geographically as well as marginalized or underserved groups must be at the centre of emergency preparedness. Volunteers need to be trained and equipped with resources necessary to deliver services on a routine basis as well as in all phases of an emergency. Close linkages with communities and health systems, and effective coordination with all parties involved in disaster risk management are essential to ensure an immediate and effective local response to health needs after a disaster.

Protracted crisis settings will require different modes of service delivery to enhance accessibility of services. For example, mobile clinics have been successfully utilized in Afghanistan for community outreach and family planning services by the Afghan Red Crescent Society.

The specific activities that CBHWs will implement will depend on the scope of the programme, country settings, funding, country regulations regarding dispensing of drugs by CBHWs and skills and training of CBHWs themselves. Once the situational analysis has been reviewed, appropriate interventions from the following essential evidence-based interventions can be delivered by CBHWs at home, community and primary care levels. Communities are not expected to deliver all of the evidenced-based interventions at once but should prioritize based on findings from the situational analysis.

Figure 4: Summary of essential evidence-based health services packages for delivery at the community/home levels



Sexual, reproductive, maternal, neonatal, child and adolescent health

CBHWs have been instrumental in connecting community members to health services and in improving the health of mothers, newborns and children by promoting vaccination uptake, breastfeeding and education on infectious diseases and making referrals for emergency obstetric care[42-45]. CBHW programmes increase contraceptive usage, especially where unmet need is high, access is low and geographic or social barriers to use of services exist[46].

Integrated community case management (iCCM): iCCM strategy uses simplified Integrated Management of Childhood Illnesses protocols to treat common childhood illnesses in children aged 2—59 months in community settings. CBHWs are trained, equipped and supervised to deliver treatment for diarrhoea, malaria and pneumonia, and in some contexts, for dysentery, newborn sepsis and malnutrition. The interventions require the use of four low-cost medicines (antimalarial, antibiotic, ORS and zinc) and one rapid diagnostic test in addition to the Mid-Upper Arm Circumference (MUAC) strip. iCCM encompasses treatment for childhood pneumonia with antibiotics, diarrhoea with zinc and ORS, and malaria with artemisinin combination therapy (ACT). Children with severe acute malnutrition are referred to the health facility. Uncomplicated cases may be managed by the CBHWs or referred to a feeding programme.

These guidelines recommend the following evidence-based interventions for sexual, reproductive, maternal, neonatal, child and adolescent health for CIC programmes[48].

Table 1: Essential, evidence-based, community-based sexual, reproductive, maternal, neonatal, child and adolescent health interventions suitable for delivery by CBHWs, including trained volunteers

Interventions	LMIC	HIC	Emergency settings	Protracted crisis settings
Adolescents and pre-pregnancy adults				
Counselling and provision of family planning/ contraceptive methods for birth spacing and safe sex (condoms and pills), including emergency contraception	X	X	X	X
Refer for family planning methods not available at community level such as longer-acting methods (injectables, implants, IUDs) and permanent methods (male and female sterilization)	X		X	X
Raise awareness about signs of domestic/sexual violence and develop plan on where to seek support and care	X	X	X	X
Detect pregnancy using pregnancy test and counsel on contraceptive or pregnancy options	X	X	X	X
Counselling, prevention messaging and managing sexually transmitted infections (STIs) through syndromic case management (as per protocols in country)	X	X	X	X

Interventions	LMIC	HIC	Emergency settings	Protracted crisis settings
Folic acid supplementation	X			X
Disseminate information on menstruation and hygiene and distribute menstrual hygiene management materials (pads, cloths, underwear, etc.) and items to support use	X		X	X
Pregnancy care				
Management of unintended pregnancy • Information about the services available for safe abortion care when indicated • Provision of post abortion care	X		X	X
Provide information and counselling on appropriate care-seeking, self-care at home, companionship during childbirth, skilled care for childbirth, nutrition, exclusive breastfeeding	X		X	X
Screening for anaemia, maternal illnesses, hypertensive disorders of pregnancy	X			X
Provide appropriate antenatal care package • Iron and folic acid to prevent maternal anaemia • Counselling on family planning, birth and emergency preparedness • Prevention and management of HIV, including antiretrovirals • Distribution of insecticide-treated bed nets to prevent malaria • Intermittent presumptive therapy for malaria for women living in endemic areas	X		X	X
Birth and complication preparedness: educate families on monitoring signs of labour and danger signs and need for urgent referral to hospital	X		X	X
Counselling and provision of family planning/ contraceptive methods for birth spacing and safe sex (condoms and pills), including emergency contraception	X		X	X
HIV testing and TB screening (regardless of HIV status) as well as support for adherence throughout the necessary diagnostic processes and adherence to treatment or TB preventive therapy, as necessary	X			X
Promote and support prevention of mother-to-child transmission and interventions to prevent and manage HIV and TB (in settings with high HIV prevalence: discuss plans for childbirth, discuss ARVs – when to start, where to keep the medication –, introduce information regarding infant feeding options)	X		X	X

Interventions	LMIC	HIC	Emergency settings	Protracted crisis settings
Low-dose aspirin in pregnancy for at-risk women as per national protocols	X		X	X
Childbirth care				
Provide continuous support to skilled birth attendant for childbirth (when institutional delivery is not possible)	X		X	X
Support for transport to and from health facility (where possible)	X		X	X
Cord care, delivery kits for clean delivery practices	X		X	X
Administer misoprostol to prevent postpartum haemorrhage, only where a well-functioning CBHW programme already exists, skilled birth attendants are not present and oxytocin is not available (as per national protocol)	X			X
Post-natal/postpartum care (mother)				
Provide information and counselling on self-care at home, nutrition, safer sex, breastfeeding, keeping baby warm, handwashing, birth spacing and family planning, healthy lifestyle including harmful effects of smoking and alcohol use, prevention and management of malaria	X		X	X
Recognize danger signs and refer urgently to hospital	X		X	X
Support women living with HIV including ART and TB screening, prevention and care regardless of HIV status	X		X	X
Report birth and death (vital registration)	X		X	X
Counselling and provision/availability of family planning/contraceptive methods for birth spacing and safe sex (condoms and pills), including emergency contraception	X		X	X
Prevent and treat maternal anaemia	X		X	X
Newborn care				
Basic newborn care and care of low birth weight infants (three home visits after birth at days 1, 3 and 7; extra visit for small babies at days 1, 2, 3, 4, 14; visit referred babies on the day they return home)	X		X	X

Interventions	LMIC	HIC	Emergency settings	Protracted crisis settings
Promote essential newborn care, including: • Keeping the baby warm • Exclusive breastfeeding (early initiation within the first hour) • Handwashing for people handling the baby • Hygienic cord and skin care	X		X	X
Care for small baby without breathing and feeding problems: • Essential newborn care • Promote continued Kangaroo Mother Care after initiation at the health facility • Frequent breastfeeding	X		X	X
Newborn stimulation and play	X		X	X
Provision of insecticide-treated bed nets for the family	X			X
Recognize danger signs on home visits and refer urgently to hospital	X		X	X
Promote routine immunization according to national guidelines	X		X	X
Promote and support timely ARV prophylaxis in HIV-exposed newborns	X		X	X
Promote and support proper feeding practices in HIV-exposed newborns as per national policies	X		X	X
Infancy and childhood care				
Exclusive breastfeeding for the first six months of life; add complementary feeding six months onwards	X		X	X
Promote and support child stimulation, appropriate play and communication activities	X		X	X
Referral of children under 12 months and in contact with a TB case to the clinic for further assessment, regardless of HIV status	X			X*
Systematic screening of children 12 months and above for TB signs in households affected by TB, and referral of symptomatic children for further assessment	X			X*
Promote and provide insecticide-treated bed nets	X			X
Provide vitamin A supplementation from six months of age in vitamin A deficient populations	X			X

Interventions	LMIC	HIC	Emergency settings	Protracted crisis settings
Promote routine immunization according to national guidelines	X		X	X
Identify and manage diarrhoea, pneumonia, malaria, malnutrition (iCCM) • Improved diarrhoea management (zinc and oral rehydration treatment (ORT)) • Community detection and management of pneumonia with short course of amoxicillin • Improved case management of malaria including ACTs • Screen for malnutrition with MUAC strip	X		X	X
Identify and refer complicated cases of childhood illness and malnutrition	X		X	X
Advocate for prevention of female genital mutilation	X			X

**Refer to section on TB for interventions in emergency and protracted crises settings*

Communicable diseases

Malaria

Community-based malaria prevention and care is provided as part of iCCM activities as well as a stand-alone activity. Rapid diagnostic tests (RDT) are now available to assist with diagnosis of cases. Studies have shown that CBHWs are capable of safely and accurately diagnosing malaria with RDTs if sufficient training and job aids are provided[49,50]. Furthermore, training CBHWs to administer ACT to malaria-confirmed patients significantly decreases inappropriate anti-malarial use (if ACT supply is maintained). This is an effective way of improving overall child health and reducing patient burden in health facilities[38,51]. CBHWs have also been effective in promoting use of bed nets and care seeking for malaria in the community[52]. Malaria treatment and surveillance by CBHWs in conflict settings was also found to be effective[53]. These guidelines recommend the following essential evidence-based practices that can be executed by CBHWs for the prevention and control of malaria[54].

Table 2: Evidence-based essential community-based malaria interventions suitable for delivery by CBHWS, including trained volunteers

Interventions	LMIC	HIC	Emergency settings	Protracted crisis settings
Educate community members on prevention and treatment of malaria	X		X	X
Distribute long-lasting insecticide-treated bed nets	X			X
Provide seasonal malaria chemoprevention to children aged 3—59 months throughout the high malaria transmission season (only in Sahel region of Africa)	X			X

Intermittent presumptive therapy for malaria for women living in endemic areas	X			X
Screen for malaria using RDT for children aged 2—59 months as per iCCM protocol	X			X
Provide home-based management of malaria (uncomplicated cases) as per iCCM protocol	X			X
Refer patients with signs of severe illness	X	X	x	X

Tuberculosis

Community-based TB activities are conducted outside of health facilities in community-based structures such as schools or places of worship by CBHWs or volunteers. Community-based directly observed therapy, short course (CB-DOTS) has been found to be effective in treating TB with higher treatment success than clinic-based DOTS44,56. CB-DOTS is convenient, cost-effective, time-saving and reduces the workload at health services57. CBHWs' roles include facilitating access to diagnostic services (referral, sputum or specimen collection, transport), initiation and provision of TB prevention measures (isoniazid prevention therapy, TB infection control), treatment adherence support through peer support and education and follow-up.

These guidelines recommend the following essential community-based interventions for TB prevention and control to be delivered by CBHWs[58,59].

Table 3: Evidence-based essential community-based TB interventions suitable for delivery by CBHWS, including trained volunteers

Interventions	LMIC	HIC	Emergency settings*	Protracted crisis settings*
Support BCG vaccination in all children for TB prevention	X		X	X
Sensitize and educate communities on TB prevention, symptoms, screening, early treatment and available services	X			X
Screen, identify and refer TB suspects/cases to health facility for diagnosis and management	X			X*
Collect sputum samples and safely transport to facility	X			X*
Counsel all TB patients and family members	X			X*
Offer HIV testing and counselling to couples, pregnant women, TB patients and people with presumptive TB	X			X*
Support and supervise implementation of DOTS	X			X*

Support patient's adherence to TB medication and other therapies	X			X*
Provide health education to family members to create a positive attitude towards the patients and to reduce stigma	X			X*
Refer TB patients on treatment for follow-up sputum smears	X			X*
Identify TB complications, including adverse drug reactions, and refer	X			X*
Identify defaulters, initiate tracing and refer the patient to the health facility	X			X*
Ensure update of patients' records	X			X*

** In the acute phase of an emergency, when mortality rates are high due to acute respiratory infections, malnutrition, diarrhoeal diseases and malaria (where prevalent), TB control is not a priority. A TB programme is implemented in places where TB is a public health problem, once the acute phase of emergency is over and essential needs have been met, stability of the population is ensured for six months, funding is available for at least 12 months and laboratory services are available*[59].

HIV/AIDS

In 2008, the World Health Organization endorsed task shifting to allow lower cadres of health workers to assume greater responsibility in HIV care delivery[17]. CBHWs have been effective in HIV/AIDS prevention and control activities, educating communities and performing tasks such as testing, counselling and providing antiretroviral drugs. Task shifting from higher-level providers and clinic-based care to CBHWs can enhance the reach, uptake and quality of HIV services, as well as the dignity, quality of life and retention in care of people living with HIV[21,60]. CBHWs have successfully improved adherence to ART and are cost-effective in providing ART in a variety of settings[61,62]. Task shifting and community-based outreach involving CBHWs effectively link people living with HIV to provision of care[63].

CBHWs should be trained in taking informed consent from patients in a non-judgmental and non-biased manner. By maintaining patient confidentiality throughout the provision of health services, CBHWs can establish trust with their clients while further protecting them from encountering undue social discrimination[64]. Protective equipment such as gloves must be provided to health workers conducting home-based HIV tests. Access to voluntary counselling and HIV testing services, isoniazid prophylaxis for nosocomial TB, co-trimoxazole prophylaxis, post-HIV exposure prophylaxis and ART and TB care should be available to all health staff and their families.

The IFRC and the Global Network of People Living with HIV (GNP+) promote the **seek-test-treat-succeed** model, which builds on the current role of the Red Cross Red Crescent CBHWs and people living with HIV networks in the HIV response[65].

- SEEK: Mobilize and engage affected communities in the HIV response, facilitate (early) access to HIV testing and counselling, improve treatment and rights literacy and support health-seeking behaviour.
- TEST: Optimize the treatment cascade by bringing HIV testing and counselling services closer to people, increase demand for it and improve the quality of these services, i.e. accessibility, acceptability, affordability, coverage and linkages.

- TREAT: Facilitate early ART initiation at primary level facilities and shift ART-related tasks, such as drug dispensing, treatment adherence and helping people living with HIV to navigate through the health system, to community health workers and volunteers.
- SUCCEED: Shift tasks to community-based organizations, empowering communities to provide support for retention and re-engagement into care, integrating HIV testing and counselling and antiretroviral therapy services with other health and social services, development issues and addressing structural barriers through optimizing positive health, dignity and prevention throughout the treatment cascade.

These guidelines recommend the following evidence-based HIV interventions for delivery by CBHWs at community level[48,66,67].

Table 4: Evidence-based essential community-based HIV interventions suitable for delivery by CBHWs, including trained volunteers

Interventions	LMIC	HIC	Emergency settings	Protracted crisis settings
Sensitize and educate on HIV, STIs, TB, safer sex and condom use, including distribution of condoms and educational materials, prevention of other infections, physical activity, nutrition, clean water and other hygiene measures	X	X	X	X
Advise on prevention for people who inject drugs as part of the comprehensive package of harm reduction	X			X
Provide information on circumcision and pre-surgical counselling	X			X
Conduct testing and counselling (pre-test counselling, conduct and interpret the test, and post-test counselling)	X			X
Recognition of TB symptoms and TB prevention counselling	X			X
Provide ART, combined TB treatment, cotrimoxazole preventive therapy, and ART directly observed treatment (DOT) between regular clinical visits	X			X
Adherence, education and counselling on ART, TB treatment and isoniazid preventive therapy	X			X
Promote and support early follow-up (up to three months from starting ART), and long-term follow up (three months after initiation of ART).	X			X
Recognize side-effects of TB and/or HIV medications and encourage/assist consultation or clinic visit when necessary	X			X

Neglected tropical diseases

Neglected tropical diseases (NTD) are a group of 20 diseases that affect more than a billion people in tropical and sub-tropical countries. They are largely preventable and often curable or effectively managed through appropriate medical treatment to avoid functional limitations. However, access to quality health care facilities and services is severely lacking in almost all regions of sub-Saharan Africa where NTDs are prevalent[68]. Community-directed treatment of ivermectin for onchocerciasis was adopted as a strategy almost 25 years ago and has also been used for control of lymphatic filariasis since then. CBHWs also play an important role in Buruli ulcer control in sub-Saharan Africa through early identification and referral linkages[69].

These guidelines recommend the following evidence-based NTD interventions for delivery in community settings by CBHWs[69,70].

Table 5: Evidence-based essential community-based NTD interventions suitable for delivery by CBHWs, including trained volunteers

Interventions	LMIC	HIC	Emergency settings	Protracted crisis settings
Educate community members on prevention, symptoms and treatment of NTDs	X		X	X
Social mobilization and environmental mitigation measures	X		X	X
Provide information on cases and serve as key local informants	X			X
Conduct screening and surveillance for NTDs like Buruli ulcer, leprosy, lymphatic filariasis	X			X
Administer mass chemoprophylaxis as part of prevention and control programmes against NTDs especially onchocerciasis, soil-transmitted helminthiasis and schistosomiasis	X			X

Noncommunicable diseases

Tackling NCDs requires complex and comprehensive solutions through the life course approach focusing on primary health care (primary, secondary and tertiary prevention). CBHWs have been effective in tobacco use cessation, hypertension and diabetes control, promoting cancer screening, improved self-management behaviours, such as keeping appointments, and adherence to medication in LMICs as well as low-income and minority populations in high income countries[7,71-76]. CBHWs were able to conduct screening using a simple, non-invasive cardiovascular disease risk prediction indicator, with a high level of accuracy to detect early disease[77]. Task shifting from physicians to CBHWs, when accompanied by health system re-structuring, is a potentially effective and affordable strategy for improving access to healthcare for NCDs[7].

NCDs in crisis settings: People living with NCDs require continuous care to avoid disease progression. Disruption of treatment due to natural disasters or emergencies poses a significant health challenge. In fragile settings, the challenge of disrupted care and treatment may be exacerbated. NCDs can have acute complications requiring immediate medical care. In the initial response (30 – 90 days of an emergency), management of NCDs should focus on treatment of life-threatening or severely symptomatic conditions. During the recovery phase after emergencies or during protracted emergencies the management of NCDs should be expanded to include management of sub-acute and chronic presentations of previously identified NCDs, as well as ongoing care and palliation[78].

These guidelines recommend the following evidence-based NCD interventions for delivery by CBHWs in the community setting[71,78,79].

Table 6: Evidence-based essential community-based NCD interventions suitable for delivery by CBHWs, including trained volunteers

Interventions	LMIC	HIC	Emergency settings	Protracted crisis settings
Educate community members on NCDs, their risk factors and prevention (healthy lifestyle, dietary habits, physical activity)	X	X	X	X
Educate community about self-screening for breast lumps and signs and symptoms of other cancers	X			
Screen, manage and follow-up for hypertension, diabetes (or a high-risk of diabetes based on age, family history, weight and level of physical activity)	X	X		
Support health systems in screening and management of cancer patients	X	X		
Measure blood pressure and blood glucose	X	X		X
Conduct foot check for diabetic ulcers	X			X
Provide treatment using a simple clinical algorithm, with appropriate supervision and support	X			X
Promote self-care by educating patients and their families on lifestyle changes and adherence to medication regimens; find ways to increase compliance with medications	X	X	X	X
Refer severe cases for treatment; follow up cases discharged from health facilities	X			X
Help patients navigate health care systems (provide assistance with enrolment, appointments, referrals, transportation to and from appointments, promote continuity of health services, arrange for childcare, arrange for bilingual providers or translators)	X	X (for elderly)		X

Provide psychosocial support by listening to the concerns of patients and their family members and help them solve problems	X	X (for elderly)	X	X

Mental health and psychosocial support (MHPSS)

Mental, neurological and substance use (MNS) disorders are prevalent in all regions of the world. Depression and anxiety, commonly seen in primary healthcare practice, are the leading neuropsychiatric causes of the global burden of disease[80]. Over two thirds of people with MNS disorders do not receive the care they need[81]. This treatment gap widens considerably in emergency and protracted crisis settings, as the prevalence of mental distress and disorders rises, whilst the capacity of formal and non-formal systems of care decreases markedly. This results not only in enormous suffering and disability but also in delayed recovery and rebuilding efforts. It can also exacerbate the outcomes of co-occurring conditions, such as TB, cardiovascular disease or diabetes.

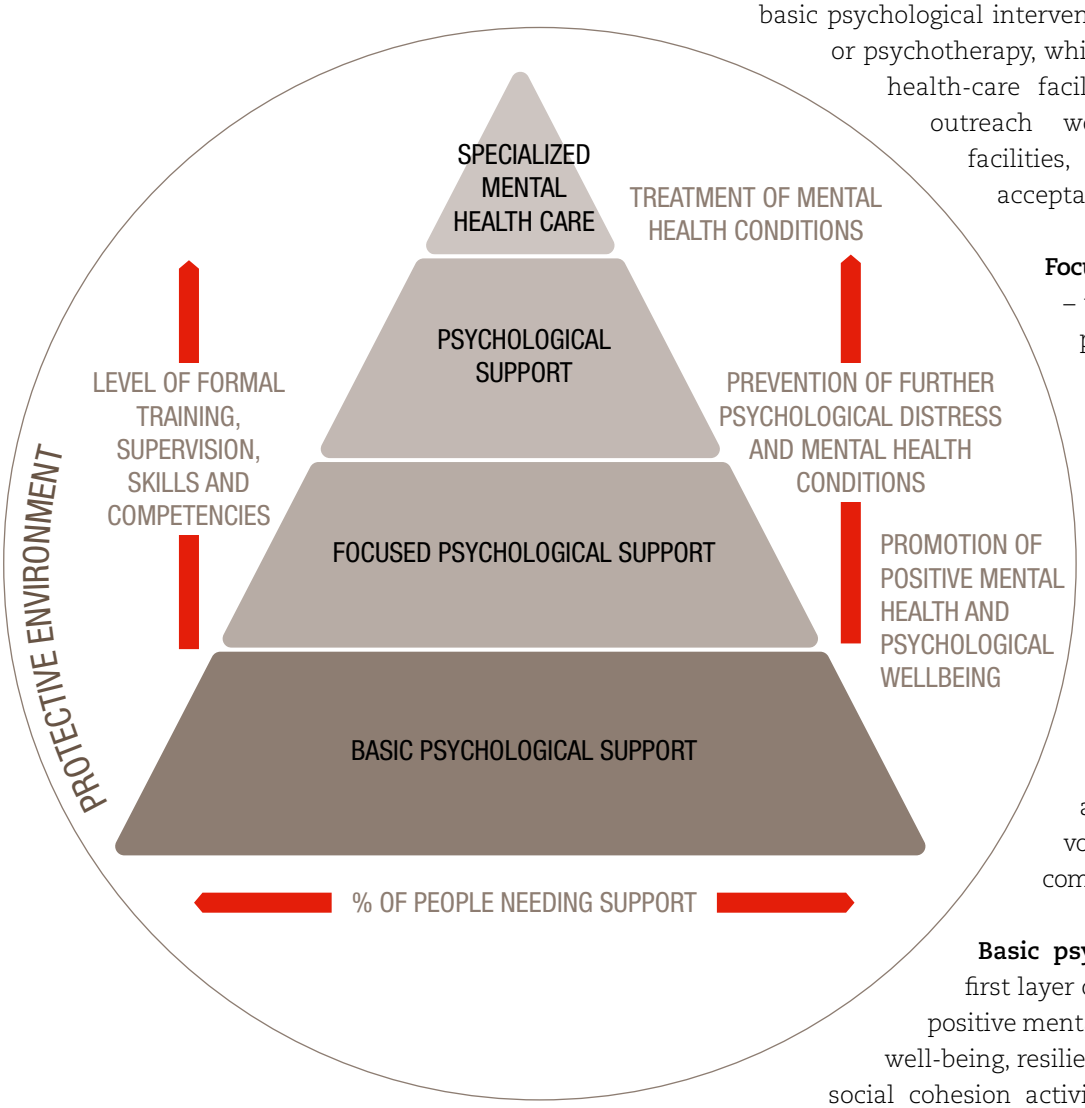
Addressing mental health and psychosocial needs is a central part of the Red Cross Red Crescent network's broader objectives to prevent and alleviate human suffering, to protect life, health and dignity, and to promote health and social welfare among individuals and communities. The Psychosocial Framework of 2005—2007 of the Federation defines psychosocial support as "a process of facilitating resilience within individuals, families and communities". Psychosocial support is an integral part of the IFRC's emergency response. These objectives are also in alignment with WHO's Mental Health Gap Action Programme (MHGAP) to scale up MNS care in low- and middle-income countries. This is further supported by National Societies' auxiliary status to governments, which provides the Red Cross Red Crescent network with unique access to so-called "last mile" populations, particularly in low resource settings, where 75 per cent of those affected by MNS disorders do not have access to the treatment that they need. All CBHWs, including trained volunteers, can further MNS care capacity in delivering interventions such as psychological first aid (PFA). PFA is the provision of humane, supportive and practical psychological assistance to those in need. It does not require specialized professional certification and is therefore ideal for engaging Level 1 volunteers/CBHWs. As such, it is a useful, low-cost solution that can be scaled-up in all contexts and integrated across other sectors based on the unique needs of each community.

Figure 5 below illustrates a layered system of complementary supports needed for a population in the form of a mental health and psychosocial support (MPHSS) pyramid.

Figure 5: MPHSS model: the pyramid

Specialized mental health care – the top layer of the pyramid – includes specialized clinical care and treatment for individuals with chronic mental health conditions and for persons suffering such severe distress and over such a period of time that they have difficulty coping in their daily lives. Examples of activities include treatment centres for survivors of torture and alternative approaches to drug therapy. Services are provided within government healthcare and social welfare systems and in detention facilities.

Psychological support – the third layer of the pyramid – includes prevention and treatment activities for individuals and families who present with more complicated psychological distress and for people at risk of developing mental health conditions. Examples of activities include basic psychological interventions, such as counselling or psychotherapy, which are usually provided in health-care facilities with accompanying outreach work or in community facilities, where this is culturally acceptable.



Focused psychosocial support – the second layer – includes promotion of positive mental health and psychosocial well-being and prevention activities, with a specific focus on groups, families and individuals at risk. Examples of activities include peer support and group work. Focused psychosocial support can be provided by trained and supervised Red Cross and Red Crescent staff and volunteers and/or trained community members.

Basic psychosocial support – the first layer of the pyramid – promotes positive mental health and psychosocial well-being, resilience, social interaction and social cohesion activities within communities. Activities in this layer are often integrated into health, protection and education sectors and should be accessible to 100 percent of the affected population, where possible. Examples of activities include PFA and recreational activities. Basic psychosocial support can be provided by trained Red Cross and Red Crescent staff and volunteers and/or trained community members

The pyramid model represents the Red Cross Red Crescent framework of mental health and psychosocial support services that are required to address the needs of individuals, families and communities in all contexts. A key to organizing MHPSS is to develop a layered system of complementary support that meets the needs of different groups. This multi-layered approach does not imply that all services are provided in all layers. However, the Red Cross Red Crescent network is expected to assess, refer and advocate in relation to the full spectrum of mental health and psychosocial support presented in the model, from basic psychosocial support through to specialized mental health care.

These guidelines recommend the following evidence-based interventions for delivery by CBHWs at the community level.

Table 7: Evidence-based essential community-based MHPSS interventions suitable for delivery by CBHWs, including trained volunteers[83]

Interventions	LMIC	HIC	Emergency settings	Protracted crisis settings
Screen for common mental disorders: depression, anxiety, harmful alcohol and substance use	X	X	X	X
Identify and respond to the special needs of community members who are not functioning well	X	X	X	X
Provide basic counselling for HIV positive individuals, elderly, their family members	X	X	X	X
Preserve or support re-initiation of pre-existing support mechanisms such as groups for women, youth and people living with HIV	X		X	X
Minimize harm related to alcohol and drugs	X		X	X
Provide psychological first aid to people exposed to potentially traumatic events such as physical or sexual violence, witnessing atrocities and experiencing major injuries			X	X
Provide therapeutic interventions (within collaborative care models)	X			X
Refer people with positive screens to higher-level mental health services	X			X
Create a protocol for mental health emergencies such as suicidal ideation and acute alcohol withdrawal; refer immediately to emergency services	X	X		X

Healthy ageing

From 2015 to 2050, the proportion of the world's population aged 60 years or more will nearly double[84]. This is likely to pose social and economic challenges to individuals, communities and public authorities as an increase in support systems is needed. The Federation promotes the concept of "active ageing" and has developed a toolkit which details minimum standards, basic skills, knowledge, and training for community-based home care of older people. This includes those with disabilities and those living with chronic disease, many of whom may also be older people[85]. Various National Societies worldwide, especially in Europe, provide community and home-based care for older persons.

Home care volunteers visit the older persons at their homes to reduce social isolation and to provide support with daily activities, individual care, prevention and rehabilitation measures. The work undertaken by home care volunteers is supervised by a nurse-supervisor/programme manager. These guidelines recommend the following evidence-based healthy ageing interventions for delivery by CBHWs in community settings[85].

Table 8: Evidence-based essential community-based healthy ageing interventions suitable for delivery by CBHWs, including trained volunteers

Interventions	LMIC	HIC	Emergency settings	Protracted crisis settings
Provide psychosocial support/counselling for elderly and family members	X	X	X	X
Encourage social activities and integration in the community	X	X		X
Map needs, organize support and cooperate with others	X	X		X
Educate the elderly and family members on nutrition, prevention of falls, healthy lifestyle	X	X		X
Encourage personal care: exercise, checking vital signs (blood pressure, pulse and blood glucose)	X	X		X
Preventive services and early detection: prevention of bed ulcers, dressing of wounds if needed, blood pressure and blood sugar measurement, breast self-examination	X	X		X
Build the capacity of family members to provide day-to-day care	X	X		X
Manage simple diseases and follow-up	X	X		X
Transitional home health care (after release from hospitalization) to empower the elderly to become more involved in managing their chronic illnesses and be more confident in communicating with health care professionals	X	X		
Recognize and identify abuse	X	X		

Palliative care

Palliative care is the prevention and relief of suffering of any kind – physical, psychological, social or spiritual – experienced by adults and children living with life-limiting health problems. It promotes dignity, quality of life and adjustment to progressive illnesses, using best available evidence. It is embedded in the health-care continuum, making it an essential component of primary care. Community-based palliative care services are those offered at a community health centre or that are run with community participation[86]. It makes use of available community resources and can be successfully implemented, even if resources are limited. CBHWs or volunteers, supported by health-care professionals, provide basic home care as part of a team of health professionals. These guidelines recommend the following evidence-based interventions for delivery by CBHWs in community settings[85,86].

Table 9: Evidence-based essential community-based palliative care interventions suitable for delivery by CBHWs, including trained volunteers

Interventions	LMIC	HIC	Emergency settings	Protracted crisis settings
Identify patients with advanced life-threatening illness at different levels of care	X	X		X
Provide support to palliative care service (e.g. transport, food for patients)	X	X	X	X
Advise on non-pharmacologic methods for controlling pain	X	X	X	X
Contribute to patient home care: emotional support, basic nursing chores, help with mobility, report uncontrolled distress to higher level of care	X	X		X
Counselling, psychosocial and spiritual support	X	X	X	X
Support for patient at end of life	X	X	X	X
Support for caregivers, family members and children	X	X	X	X

Part 2B:
Care in the Communities in emergencies and protracted settings

Background

Countries in protracted crises have one of the poorest health indicators and poor health outcomes contribute to protracted states[89]. Health indicators are worse in fragile conflict-affected states as compared to non-conflict affected fragile states[90]. These countries often suffer severe disruptions to their disease control programmes and supply chain; destruction of infrastructure; displacement of communities; death/flight of health workers; and a changing burden of disease (increased injuries and illnesses associated with violence, resurgent infectious disease, mental health problems and growing burden of non-communicable diseases)[91.92.93].

Health workforce performance is also affected as training standards suffer, management systems collapse, and the working environment deteriorates. Among internally displaced people and refugees, overcrowding, inadequate shelter, poor sanitation, insufficient water quantity and quality, and reduced food security, increase the risk of malnutrition, tuberculosis, malaria, and outbreaks of other communicable diseases. The worldwide health worker shortage is not limited to countries at peace; scarcity of health workers acutely affects the delivery of health services in conflict, post-conflict, and disaster settings.

Achievement of Universal Health Coverage (UHC) requires a primary health care approach with a strong focus on fragile and conflict-affected states. Rebuilding healthcare infrastructure goes hand in hand with developing human resources for health in protracted crises[94]. Community-Based Health Worker (CBHW) programmes in protracted crises have been successful in increasing the availability and accessibility to health services[95]. Investments in community-level health systems help build a community's resilience by providing training, equipment and essential medicines to community-based providers for basic health services[96].

The Red Cross and Red Crescent Movement plays an important role in recovery and longer-term development of these fragile states. This includes strengthening community structures through the presence of CBHWs (including trained volunteers); reaching out to communities at risk; supporting local health authorities; and enabling more people to access health services. There is also an opportunity for the Red Cross Red Crescent to foster and lead locally-led responses to health issues by bringing about community participation through their programmes.

Objective

This guideline aims to support National Societies and their programme managers in designing, implementing, evaluating, and sustaining effective care in communities programmes in protracted crisis settings. The guidelines also provide a community-based health model for protracted crisis contexts with a menu of evidence-based effective health service packages and key implementation mechanisms.

Systems approach

In the protracted phase, common tools and approaches include rebuilding health facilities and systems, as well as training health care workers. In keeping with the tenets of UHC and principles of reaching the last mile and leaving no one behind, healthcare services must be:

Available: Healthcare can be delivered through a combination of community-level, mobile, and fixed healthcare facilities. Mobile services offer a good combination of ease of access and quality services but are expensive. These services can be offered in areas with high-level conflict, where infrastructure has been damaged or distances are too great to travel to facilities. Prioritisation for the most affected areas or population could be a viable strategy.

Acceptable: National Societies must consult with all sections of the community to identify and address obstacles to accessing healthcare services, especially at-risk groups, and to understand health-seeking behaviour and use this information in recruitment, training and service delivery by CBHWs.

Affordable: The services provided by CBHWs should be free or as per government health authorities.

Situation Analysis: This will necessitate a review of existing national policies and protocols, existing clinical guidelines, tools, and training materials. National Societies must avoid reinventing programmes and protocols that already exist or developing new recommendations that may conflict with current standards. An assessment of resource availability (health facilities, supplies and staff) as well as community access to, and utilization of, these available health services, is required. Reviewing records, using pre-crisis data, and conducting household surveys or epidemiological assessment with a cross-sectional survey may be necessary. Finally, assessment of staff availability and competencies at the facility or community level may be required. Specifically, identification of the number and type of skilled and unskilled health care providers available in each locality and identification of where they work (e.g. mobile clinic, as outreach workers, within an existing health centre).

Developing the programme: The National Society will need to summarize key findings from the assessment. Following this assessment, they will need to identify which CBHW interventions should be developed and implemented in response to those findings and in coordination with the community, government, local NGOs, and other international agencies. If the government does not have access to, or would not be

accepted in, all areas of the country, the National Society should seek to support the existing accepted system. The National Society must carefully consider how best to work with non-state actors and other partners, especially in terms of their ability to provide or coordinate healthcare for the population.
An MoU needs to be signed to lay out the roles and responsibilities of all partners at all levels. To avoid loopholes in service delivery, the roles of government agencies, the Red Cross Red Crescent, affected populations, and other partners, must be clearly delineated. This is particularly important to ensure the continuity of services for internally displaced people moving from one province/territory to another. All programmes should establish links with the nearest primary healthcare facility to ensure integrated care, clinical supervision, and programme monitoring.

Recruitment of CBHWs

Selection criteria

CBHWs should be selected based on key criteria such as educational qualifications, residence in the target community, personal attributes, age, and gender. Selection criteria should align with the government's criteria (where available). In protracted settings, some criteria, such as educational qualification, may need to be relaxed. Target communities should be involved in CBHW selection. If the National Society has an existing pool of trained volunteers, selection of CBHWs can be done from this group. Attrition among CBHWs is generally high in protracted settings. Therefore, a larger number of CBHWs should be selected at the initiation of the programme.

The Sphere Handbook recommends a minimum of 1-2 CBHWs per 1,000 people[97]. If there are geographical constraints or acceptability issues in diverse communities, one CBHW may be able to serve much fewer people.

Training

In protracted settings, CBHW training courses must be practical and will require the condensing of extensive amounts of information into brief training that health workers can complete within the restrictions of their work schedules and the crisis situations surrounding them. Training venue, methods and materials will require comprehensive restructuring. External trainers may need to be recruited, especially during the initiation of large-scale training programmes. Core competencies for CBHWs must be encapsulated in the training. Training programmes should follow national guidelines (adapted for emergencies) where available and must incorporate approved community-level key messages and referral system protocols.

Pre-service and in-service training will need to be incorporated. Types of training may include on-the-job sessions, practical or theoretical lessons in a classroom-style setting, structured training courses that address a specific task or need, and refresher courses for longer-term/ experienced health worker.

Effective training techniques supported by technology (such as a good mix of online training in small modules, work settings, and other evidence-based adult learning techniques) provide optimal training outcomes, particularly when training programs are adapted to CBHWs' work, the setting in which they will work, and local health needs[98].

Supportive supervision

Regular appraisal should complement supportive supervision and training to ensure workers perform at the required levels based on job descriptions[99]. Although challenging to implement and sustain within crisis settings, supervision and evaluation of CBHW practices are essential to the delivery of high-quality services.

Depending on the setting, supervisors may be from the local health system or from within the Red Cross Red Crescent system. The supervisor will do on-site visits to monitor CBHWs interventions as well as provide mentoring, gather data, and identify gaps in performance to strengthen CBHW skills on the job. The supervisor should be provided with transport and other material support to ensure their active engagement in the supervisory process. When logistical challenges arise, such as impassable roads or security alerts that prevent local visits, on-site supervision may be suspended but must resume as soon as feasible. Alternative means of providing supportive supervision, such as through cell phone calls, are recommended to overcome barriers to in-person follow-up[88]. Where possible, build on mHealth for effective supervision and training.

Incentives

A literature review of incentives and motivating factors for CBHWs in protracted crisis settings showed that these factors were similar to non-crisis settings[30,100,101].These include community recognition; opportunities for training and supervision; career development; indirect financial incentives such as free health care and education; involvement in local health facility operations and management committees; and financial incentives such as per diems. Incentives must be aligned with the role and responsibilities of CBHWs (e.g. per number of hours put in, etc).

While a mix of financial and non-financial incentives are recommended, it is important that financial incentives provided be sustainable in the long term, especially when the programme is taken over by the government. In addition, it is also imperative to provide a safe workplace and adequate supplies to CBHWs and volunteers.

Referral

Referral needs to be established to the nearest health care facility and should be taken into account during the planning of the overall intervention. Security constraints and transport shortages can cripple referral services in crisis settings.

Supply chain

Supply and cold chains have to be ensured. This includes medicines and other supplies made available to health facilities close to the community for distribution to CBHWs. Under stable circumstances, the Red Cross Red Crescent does not engage in supply chain management. However, under crisis situations, the Red Cross Red Crescent may be the only organization with access to the population and therefore may be engaged in supply chain management. Medicines should be as per the MoH essential medicines list and protocols where this exists. Otherwise, international standards should be used. In purchasing essential medicines, the quality of the drugs must be guaranteed and “humanitarian pricing” by pharmaceutical manufacturing organizations should be explored.

Reporting, monitoring and evaluation

CIC programmes need to have strong built-in reporting mechanisms. Reports may be collected by supervisors during visits or be transmitted over the phone (mHealth). An overall M&E plan should be developed that utilizes standardized methods of data collection, reporting for assessments and ongoing monitoring. Depending on the crisis situation, some indicators may be inappropriate and others may need to be adapted or added.

Sustainability

The sustainability of CIC programmes requires enhanced innovations to strengthen supportive supervision. This includes mechanisms to highlight the role of CBHWs and to demonstrate recognition of, and appreciation for, CBHWs' efforts and accomplishments.

Quality of care

Strong supervision and mentoring of CBHWs, with appropriate levels of autonomy and support for supervisors, are essential to ensuring a high quality of care. Use of data provides an opportunity to reward CBHWs and monitor good practice.

Job descriptions and tasks

Job descriptions and tasks need to be centrally defined and be very clear in outlining the roles and responsibilities of CBHWs. This should be conveyed in clear terms to the staff at all levels of healthcare. The Red Cross Red Crescent needs to coordinate with the health authorities and other partners to prioritize and implement health interventions. During an emergency, only the most essential services can be provided. However, in protracted crises settings, efforts should be made to provide a more comprehensive set of health services and interventions. The interventions implemented under each service should be tailored to the setting to ensure that they are appropriate and affordable. Sphere standards should be used as a guide. Increased access to services must not come at the expense of quality, which is a crucial cross-cutting issue that cannot be neglected.

Essential evidence-based health services packages for delivery at the community/home levels

Sexual, reproductive, maternal, neonatal, child and adolescent health

Pregnant women, newborns and children are extremely vulnerable in humanitarian situations. Unsafe deliveries increase as skilled birth attendants and emergency obstetric care become unavailable. This is compounded by population displacement, trauma, malnutrition, disease and increased sexual and gender-based violence as social protection systems and norms break down. Most organizations implement the Minimum Initial Service Package developed by the Inter-Agency Working Group on Reproductive Health in Crises[102]. Programmes focus on providing a range of basic health services at the onset of an emergency and then expand on these, adding more comprehensive services. Common tools and approaches in the onset phase include:

- Mobilizing surge emergency healthcare staff to provide services
- Establishing temporary health outposts close to crisis-affected communities and designing referral systems for women and newborns in need of more comprehensive care
- Providing mobile services
- Ensuring health workers have the necessary supplies (equipment, drugs etc.) by deploying emergency health care kits
- Raising awareness amongst the affected population on how to access services.

In the protracted phase, common tools and approaches include rebuilding health facilities and systems and training national and local health care workers. Some examples of this are training mobile health workers to provide elements of basic emergency obstetric care, blood transfusions and antenatal care in eastern Myanmar; and training community health workers in Afghanistan to strengthen the link between the community and formal health services[103.]

Access to reproductive, maternal, and child health services is limited in fragile settings with women and adolescent girls at greater risk of sexual and gender-based violence. Programmes utilizing CBHWs demonstrated an increase in the use of contraceptives, antenatal services, presence of a skilled birth attendant, use of emergency obstetric care services, and a decline in maternal mortality rate[103-108].

Deploying lay refugees or internally displaced people as CBHWs to provide basic health services to women, children, and families in camps can increase service coverage; knowledge about disease symptoms and prevention; uptake of treatment and protective behaviours; and access to reproductive health information[109].

Despite not being designed for crisis contexts, community-based health care initiatives that heavily rely on CBHWs, such as Integrated Community Case Management (iCCM), have saved lives and demonstrated resilience in emergency settings (both conflicts & epidemic contexts)[88].

Table 1: Essential, evidence-based, community-based sexual, reproductive, maternal, neonatal, child, and adolescent health interventions suitable for delivery by CBHWs including trained volunteers in protracted crises[48,110,111].

Interventions	
Adolescents, and pre-pregnancy adults	Counselling and provision of family planning/ contraceptive methods for safe sex and birth spacing (condoms and pills), including emergency contraception
	Refer for family planning methods not available at the community level (longer-acting methods (injectables, implants, IUDs); permanent methods (male and female sterilization))
	Raise awareness about signs of domestic/sexual violence and develop a plan on where to seek support and care
	Counselling, prevention messaging and managing STIs through syndromic case management (as per protocols in-country)
	Folic acid supplementation
	Disseminate information on menstruation and hygiene and distribute menstrual hygiene management materials (pads, cloth, underwear etc) and items to support the use

Pregnancy care	Identify pregnant women in crisis-affected populations
	Management of unintended pregnancy • Information about the services available for safe abortion care when indicated • Provision of post-abortion care
	Provide information and counselling to pregnant women on nearest health facility for skilled antenatal and childbirth care, self-care at home, companionship during childbirth, nutrition, exclusive breastfeeding
	Screen for anaemia, hypertensive disorders of pregnancy, other maternal illnesses
	Provide an appropriate antenatal care package • Iron and folic acid • Counselling on family planning, birth and emergency preparedness • Prevention and management of HIV, including antiretrovirals • Distribution of LLITN to prevent malaria •I ntermittent presumptive therapy for malaria for women living in endemic areas
	Birth and complication preparedness: educate families on monitoring of signs of labour and danger signs and need for urgent referral to hospital
	If women are unable to go to a health facility for antenatal care and/or labour/birth: • Provide education on danger signs, need for referral, and referral pathways • Provide the family with a clean birth kit and information about safe birth practices and newborn care • If home birth occurs, encourage women and caretakers to visit a health facility as soon as possible after birth to examine mother and baby • Distribute newborn care supplies intended for household use
	Counselling and provision of family planning/ contraceptive methods for birth spacing and safe sex (condoms and pills), including emergency contraception
	HIV testing and TB screening (regardless of HIV status) as well as support for adherence to diagnostic processes and treatment or TB preventive therapy, as necessary
	Promote and support PMTCT and interventions to prevent and manage HIV and TB (in settings with high HIV prevalence) PMTCT: discuss plans for childbirth, discuss ARVs (when to start, where to keep it), introduce information regarding infant feeding options
	Low-dose aspirin in pregnancy for at-risk women as per national protocols
Childbirth care	Provide continuous support to the skilled birth attendant for childbirth (when institutional delivery is not possible)
	Support for transport to and from a health facility (where possible)
	Cord care, delivery kits for clean delivery practices
	Administer misoprostol to prevent postpartum haemorrhage, only where a well-functioning CBHW programme already exists, skilled birth attendants are not present, and oxytocin is not available (as per national protocol)

Post-natal/ Postpartum care (mother)	Provide information and counselling on self-care at home, nutrition, breastfeeding, keeping baby warm, hand washing, a healthy lifestyle including harmful effects of smoking and alcohol use, prevention and management of malaria
	Recognize dangers signs and refer urgently to hospital
	Support women living with HIV including ART and TB screening, prevention, and care regardless of HIV status
	Counselling and Provision/availability of family planning/ contraceptive methods for birth spacing and safe sex (condoms and pills), including emergency contraception
	Prevent and treat maternal anaemia
	Report birth and death (vital registration)
Newborn care	Basic newborn care and care of low-birth-weight infants (3 home visits at day 1, 3 and 7; extra visits for small babies at day 1, 2, 3, 4, 14; visit referred babies on the day they return home
	Promote essential newborn care, including: • Keeping the baby warm • Exclusive breastfeeding (early initiation within the first hour) • Hand washing for people handling the baby • Hygienic cord and skincare
	Care for small baby without breathing and feeding problems: • Essential newborn care • Promote continued Kangaroo Mother Care after initiation at the health facility • Frequent breastfeeding
	Recognize danger signs on home visits and refer urgently to hospital
	Newborn stimulation and play
	Provision of insecticide-treated bed nets for the family
	Promote routine immunization according to national guidelines
	Promote and support timely ARV prophylaxis in HIV-exposed newborns
	Promote & support proper feeding practices in HIV-exposed newborns as per national policies
Infancy and childhood care	Exclusive breastfeeding for the first 6 months of life and complementary feeding 6 months onwards
	Promote and support child stimulation, appropriate play, and communication activities
	Referral of children under 12 months and in contact with a TB case to the clinic for further assessment, regardless of HIV status*
	Systematic screening of children 12 months and above for TB signs in households affected by TB, and referral of symptomatic children for further assessment*
	Promote and provide insecticide-treated bed nets
	Provide vitamin A supplementation from 6 months of age in Vitamin A deficient populations
	Promote routine immunization according to national guidelines
	Identify and manage diarrhoea, pneumonia, malaria, malnutrition (iCCM) - Improved diarrhoea management (zinc and ORT) - Community detection and management of pneumonia with a short course of amoxicillin - Improved case management of malaria including ACTs - Screen for malnutrition with MUAC strip
	Refer to complicated cases of childhood illness and malnutrition
	Advocate for prevention of female genital mutilation

**Refer to the section on TB for interventions in protracted settings*

Tuberculosis

During protracted crises, the challenges of ensuring uninterrupted treatment, preventing treatment failure and guarding against multidrug-resistant tuberculosis are exacerbated. The risk of infection spreading among populations affected by the crisis is high because of overcrowding and malnutrition, especially among internally displaced people.

Local communities can strengthen TB case finding, treatment adherence and contact tracing to avoid a loss to follow up, and improve treatment outcomes in fragile settings[112-114].

In the acute phase of an emergency, when mortality rates are high due to acute respiratory infections, malnutrition, diarrhoeal diseases, and malaria, TB control is not a priority. A TB programme is implemented in places where TB is a public health problem once the acute phase of an emergency is over and essential needs have been met; stability of the population is ensured for 6 months; funding is available for at least 12 months; and laboratory services are available[115].

Table 2: Essential, evidence-based, community-based tuberculosis interventions suitable for delivery by CBHWs including trained volunteers in protracted crises[59]

Interventions	
TB Interventions	Support BCG vaccination in all children for TB prevention
	Sensitize and educate communities, patients and relatives on TB prevention, symptoms, screening, early treatment and available services and to reduce stigma
	Screen, identify and refer TB suspects/cases to a health facility for diagnosis and management
	Collect sputum samples and transport to a health facility
	Offer HIV testing and counselling to pregnant women, TB patients and people with presumptive TB
	Support and supervise the implementation of DOTS to patients for whom they are responsible
	Support patient's adherence to TB and other therapies
	Refer TB patients on treatment for follow-up sputum smears
	Identify TB complications, including adverse drug reactions, and refer
	Identify defaulters, initiate tracing and refer the patient to the health facility
	Refer contacts for assessment
	Ensure update of patients' records

HIV/AIDS

Access to HIV/STI prevention can often be limited, inadequate, and even non-existent as a result of humanitarian crises[116]. For HIV-positive populations (including HIV-positive pregnant women and new mothers), continuity of care and treatment can be difficult due to the sporadic availability of ART, which is often not available at the primary care level[92].

Table 3: Essential, evidence-based, community-based HIV interventions suitable for delivery by CBHWs including trained volunteers in protracted crises

Interventions	
HIV Interventions	Sensitize and educate on HIV, STIs, TB, safer sex and condom use, prevention of other infections, physical activity, nutrition, clean water, and other hygiene measures
	Provide condoms and educational materials
	Advice on prevention for people who inject drugs as part of the comprehensive package of harm reduction
	Provide information on circumcision and pre-surgical counselling
	Conduct testing and counselling (pre-test counselling, conduct and interpret the test, and post-test counselling)
	Recognition of TB symptoms and TB prevention counselling
	Provide ART, combined TB treatment, cotrimoxazole preventive therapy, and ART directly observed treatment (DOT) between regular clinical visits
	Adherence, education and counselling on ART, TB treatment and isoniazid preventive therapy
	Promote and support early follow-up (up to 3 months from starting ART), and long-term follow up (3 months after initiation of ART).
	Recognize side-effects of TB and/or HIV medications and encourage/assist consultation or clinic visit when necessary

Malaria

With almost two-thirds of the world's refugees, internally displaced people, returnees and other persons of concern to the UNHCR living in malaria-endemic regions, malaria remains a significant threat to the health of refugee populations, particularly in sub-Saharan Africa[59]. Migration from regions of low to high malaria endemicity heightens malaria risk in susceptible refugee populations[118]. Conversely, influxes of refugee populations from regions of high to low endemicity may result in malaria transmission to susceptible host country populations if suitable vectors are present. CBHWs have been found to be effective for malaria treatment and surveillance in conflict settings[53].

Table 4: Essential, evidence-based, community-based Malaria interventions suitable for delivery by CBHWs including trained volunteers in protracted crises

Interventions	
Malaria Interventions	Educate community members on the prevention and treatment of malaria
	Distribute long-lasting insecticide-treated bed nets
	Provide seasonal malaria chemoprevention to children aged 3-59 months throughout the high malaria transmission season *(only in Sahel region of Africa)*
	Intermittent presumptive therapy for malaria for women living in endemic areas
	Conduct rapid diagnostic testing for malaria for children aged 2 months-59 months as per iCCM protocol
	Provide home-based management of malaria (uncomplicated cases) using artemisinin-based combination therapies as per iCCM protocol
	Refer patients with signs of severe illness

Neglected tropical diseases

Prevention and control of NTDs is a challenge in crisis settings as there is both increased exposure and in susceptibility to infection.

Table 5: Evidence-based essential community-based NTD interventions suitable for delivery by CBHW including trained volunteers in protracted crisis settings

Interventions	
Neglected Tropical Diseases	Educate community members on prevention, symptoms, and treatment of NTDs
	Social mobilization and environmental mitigation measures
	Provide information on cases and serve as key local informants
	Conduct screening and surveillance for NTDs
	Administer mass chemoprophylaxis as part of prevention and control programmes against NTDs especially onchocerciasis, soil-transmitted helminthiasis, schistosomiasis

Noncommunicable diseases

People living with NCDs require continuous care to avoid disease progression. In fragile settings, the challenge of disrupted care and treatment may be exacerbated. NCDs can have acute complications requiring immediate medical care. In the initial response (30-90 days of an emergency), management of NCDs should focus on the treatment of life-threatening or severely symptomatic conditions. During the recovery phase after emergencies or during protracted emergencies such as long-term settlements, the management of NCDs should expand to include management of sub-acute and chronic presentations of previously identified NCDs, as well as ongoing care and palliation[78].

Screening for previously undetected NCDs is not recommended at any stage of an emergency as it causes ethical dilemmas. Screening also raises the challenge of tackling false-positive cases. However, in selected programmes, where sufficient appropriate treatment is available, active case finding could be considered during medical consultations in high-risk patients (e.g. checking blood pressure in a diabetic patient or in pregnant women).

Table 6: Evidence-based essential community-based NCD interventions suitable for delivery by CBHW including trained volunteers in protracted crisis settings

Interventions	
Noncommunicable diseases	Educate community members on NCDs, their risk factors and reduction of risk factors for NCDs (healthy lifestyle, dietary habits, physical activity)
	Measure blood pressure and blood glucose in patients with HT and DM respectively
	Conduct foot check for diabetic ulcers
	Promote self-care for diabetes including diet, foot care, etc and adherence to treatment
	Refer severe cases for treatment; follow-up cases discharged from health facilities
	Provide information about NCD services and where to access care
	Help patients navigate health care systems (e.g. by providing assistance with enrolment, appointments, referrals, and transportation to and from appointments; promoting continuity of health services; arranging for childcare or rides and arranging for bilingual providers or translators)
	Provide psychosocial support by listening to the concerns of patients and their family members and helping them solve problems

Mental health and psychosocial support

Mental health problems increase as a result of emergencies while those with pre-existing mental disorders are rendered more vulnerable[118,119]. Violence and conflicts often increase the harmful use of alcohol or drugs and, vice versa. Alcohol and drug use disorders are associated with violence and criminal behaviour.

In many countries, "psychological first aid" has been used to mitigate the effects of sexual and gender-based violence. Psychological first aid was piloted in Haiti, resulting in positive improvements among participants suffering from mental distress[120].

As per the MHPSS model of the Red Cross Red Crescent, starting at the base, the first layer of the pyramid is referred to as basic psychosocial support, which is provided by trained Red Cross Red Crescent staff, volunteers and/ or trained community members. Red Cross Red Crescent needs to work with community members, including marginalised people, to strengthen community self-help and social support and promote community dialogue on ways to address problems collaboratively, drawing on community wisdom, experience and resources.

Table 7: Evidence-based essential community-based Mental Health interventions suitable for delivery by CBHW including trained volunteers in protracted crisis settings[82]

Interventions	
Mental Health Interventions	Identify and respond to the special needs of community members who are not functioning well
	Develop and provide supports in a culturally appropriate way
	Preserve or support re-initiation of pre-existing support mechanisms such as groups for women, youth and people living with HIV
	Protect the rights of people with severe mental health conditions in the community
	Minimise harm related to alcohol and drugs; access to harm reduction tools
	Provide psychological first aid to people exposed to potentially traumatic events such as physical or sexual violence, witnessing atrocities and experiencing major injuries
	Provide basic counselling for HIV positive individuals, elderly, their family members
	Facilitate referral to higher levels of mental health care

Healthy ageing

The Federation promotes the concept of 'active ageing' and has developed a toolkit which details minimum standards, basic skills and knowledge and training for community-based home care of older people, those with disabilities and those living with chronic disease, many of whom may also be older people[85].

Table 8: Evidence-based essential community-based Healthy Ageing interventions suitable for delivery by CBHW including trained volunteers in protracted crisis settings

Interventions	
Healthy Ageing Interventions	Provide psychosocial support/counselling for elderly and family members
	Encourage social activities and integration in the community
	Map needs, organize support and cooperate with others
	Educate the elderly and family members on nutrition, prevention of falls, healthy lifestyle
	Encourage personal care: exercise, checking vital signs (blood pressure, pulse and blood glucose)
	Preventive services and early detection: prevention of bed ulcers, dressing of wounds if needed, blood pressure and blood sugar measurement, breast self-examination
	Build the capacity of family members to provide day-to- daycare
	Manage simple diseases and follow-up

Palliative care

Palliative care is "an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering"[86]. In protracted settings, palliative care is needed for patients with life-limiting illnesses whose pre-crisis palliative care is interrupted and for those whose palliative care needs are unmet or exacerbated as a result of the crisis. Older people are the most vulnerable.

Table 9: Evidence-based essential community-based Palliative Care interventions suitable for delivery by CBHW including trained volunteers in protracted crisis settings

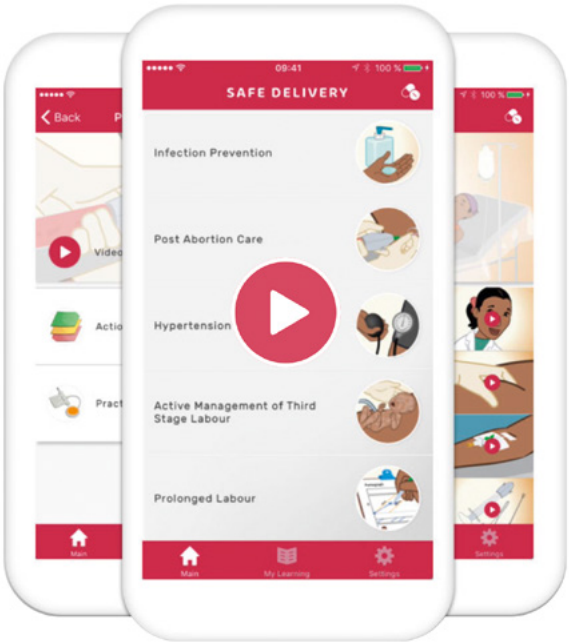
Interventions	
Palliative Care Interventions	Identify patients with an advanced life-threatening illness at different levels of care
	Provide support to palliative care service (e.g. transport, food for patients)
	Advice on non-pharmacologic methods for controlling pain
	Contribute to patient home care: emotional support, basic nursing chores, help with mobility, report uncontrolled distress to a higher level

Part 3:
Case studies

Guinea

mHEALTH: Safe Delivery App: Strengthening knowledge and confidence in basic emergency care among health workers and midwives

The *Reproductive Health Programme in Moyenne Guinée (2015—18)*, was implemented by the Red Cross Society of Guinea with consortia partners from Danish, British and Swiss Red Cross. It targeted 60,000 people in the regions of Labé and Mamou and aimed at improving the reproductive health of vulnerable communities and their resilience to epidemics.



The Safe Delivery App

The Maternity Foundation developed the Safe Delivery App, a smartphone application that provides skilled birth attendants with direct and instant access to evidence-based and up-to-date clinical guidelines on basic emergency obstetric and neonatal care in the form of easy-to-understand animated instruction videos, action cards and drug lists. It serves both as a pre- and in-service training tool and equips birth attendants, even in remote areas, with a powerful on-the-job reference tool.

In Guinea, the Safe Delivery App was launched as a 12-month pilot project in November 2016. The objective of the pilot was to assess the impact of the Safe Delivery App in terms of *strengthening knowledge and confidence in basic emergency care* among health workers and midwives associated with the programme.

The project was closely monitored and evaluated throughout. Data collection consisted of quantitative clinical assessments and qualitative methods to account for perceptions, experiences and attitudes around the App. The evaluation concluded that the App achieved its objectives in addition to having an indirect impact on motivation and general job satisfaction among health workers. It was seen as a strong add-on to the clinical and community-based efforts being carried out by the Red Cross consortium in the region.

Kenya

Home care and management of malaria[55]

Kenya Red Cross, in partnership with the Canadian Red Cross, the Canadian International Development Agency (CIDA), WHO and Division of Malaria Control (DoMC), Kenyan Ministry of Public Health and Sanitation (MOPHS), implemented a pilot community case management project in two districts (Lamu and Malindi) in the Coast Province of Kenya in 2009. These regions are characterized by low levels of access to health facilities due to difficult geographic terrain, semi-arid climate and high levels of poverty. The pilot was conducted to study factors associated with the use of CBHWs to improve access to malaria treatment in Kenya to inform national malaria control policy.

A health systems approach was utilized in the pilot, and strong management and supervision processes were set up. The district malaria focal person worked in close collaboration with the Kenya Red Cross Project Officer to manage the project activities. Community Health Extension Workers (CHEWs - full time employees of MOPHS, based in health facilities) functioned as coaches to selected groups of CBHWs. Drug packs (artemether/lumefantrine (AL)) were supplied through regular MOPHS channels based on needs, with additional logistics support from Kenya Red Cross. CHEWs met every two weeks with CBHWs at a designated health facility to verify the CBHWs' monitoring reports and address any concerns. The health facility nurse often participated in these meetings and this contributed to enhanced coordination, particularly for referrals. The project was also discussed at monthly district level meetings and independently monitored by provincial health management team members.

The pilot phase had an estimated target population of 9,600 children aged 3—59 months in 113 "hard to reach" communities. One CBHW per village was selected by the Village Committee based on predetermined selection criteria (resident of the community, respected member of the community and literate). Preference was given to pre-existing Kenya Red Cross volunteers. In areas without Kenya Red Cross volunteers, new CBHWs were recruited and registered as volunteers. Project induction training was conducted by DoMC as per the approved iCCM training curriculum. Refresher training was done after six months. At the time of project initiation, diagnosis prior to treatment was not mandated by WHO and DoMC guidelines and RDTs were not used.

Children were provided AL therapy as malaria treatment by female CBHWs for free. The project applied for and received a formal waiver for prescription of AL by CBHWs across the counter from the Pharmacy and Poisons Board together with DoMC. Supplies of age-appropriate AL packs were distributed to CBHWs by their respective coaches on a monthly basis, based on supplies used and monitoring reports of child fever cases treated. Compliance was measured from the volunteer recording forms and discussion with caregivers. Referrals to a health facility were done when there were danger signs (e.g. complicated malaria case), adverse drug reactions or treatment failure. Baseline and end line surveys were conducted using two-stage cluster sampling.

CBHWs were associated with changes in health-seeking behaviour of the community members. An increase in caregivers seeking advice/treatment from recommended sources (including CBHWs/Kenya Red Cross volunteers) was observed as opposed to asking shopkeepers, etc. CBHWs' in-depth understanding of the community's values, their residency within the community, the training and health-related equipment provided by Kenya Red Cross likely enabled them to continuously cultivate good client-service provider relationships compared to shopkeepers and health facility staff. When CBHWs were used, the child's odds of receiving AL within 24 hours were almost six times higher compared to other sources of treatment. The findings revealed a higher proportion of families seeking advice/treatment from CBHWs working with fewer than 200 households, suggesting that CBHWs were

better used when allocated fewer households. The study demonstrated that mothers from the poorest households were more likely to seek advice/treatment from CBHWs, possibly because treatment was free, CBHWs provided prompt treatment at the household level and there was high confidence in CBHWs whom communities nicknamed as "doctors of one drug" and "malaria doctor".

Montenegro

Taking care of older persons through a home care programme

The Red Cross of Montenegro (RCM) faces the challenge of increasing numbers of older people that need support, especially in remote rural areas. RCM recognizes its role in the area of social protection of older persons and is one of the most active organizations in this area due to its mandate, networking and experience with trainings of volunteers, and implementation of the **Home Care Programme**.

The Home Care Programme is carried out in 12 local branches and has been conducted since 2002. The main goal of the Home Care Programme is to contribute to poverty reduction and improvement of living conditions for older people. Care for the elderly means alleviating their problems, reducing vulnerability, and ensuring the basic needs of the elderly, orphaned and sick persons are met.

Direct beneficiaries of the programme are older people (about 1,000), most of whom are older than 65, have no or little income, live alone, or with a spouse or another person who often also needs assistance.

The trained volunteers taking part in this programme pay home visits to the elderly, run errands for them, accompany them when visiting a health facility, provide small-scale help with personal hygiene, work in the household, and so on. They are also involved in organizing other activities for the elderly - socializing, social and entertainment evenings and the like. In addition to the younger volunteers, the goal is to include senior volunteers in these activities in order to promote the concept of active ageing. A number of professionals, such as doctors and psychologists, take part in the programme as volunteers and provide expert services for the elderly.

The Home Care programme consists of service delivery, depending on the beneficiaries' need, such as:

- Health protection (blood pressure control, blood sugar control, escort when going for check-ups)
- Assistance in personal hygiene
- Working therapy – functional (movement exercise) and amusing (creative use of beneficiaries' free time)
- Assistance in providing food (food supply, preparation of hot beverages, preparation of simple meals, food serving)
- Assistance in the house (assistance in keeping clothes, shoes, sheets, assistance in hygiene keeping)
- Activities for social, cultural, recreational, creational and religious needs
- Assistance in rural areas
- Providing expert advice

Burundi, Lesotho, Rwanda and Zimbabwe

Integrated community-based approach for orphans and vulnerable children programme[87]

Four National Red Cross Societies in Africa developed and implemented programmes with Orphans and Vulnerable Children (OVC) as the target group: the Lesotho Red Cross Society (since 2002), the Rwanda Red Cross (since 2002), the Burundi Red Cross (since 2008) and the Zimbabwe Red Cross Society (since 2009). The programme has been supported by the Norwegian Red Cross (NorCross). The rationale for establishing the programmes were different based on country specific challenges (e.g. the HIV/AIDS pandemic in many countries; in Rwanda it was a direct response to the 1994 genocide).

Programme design: the programmes were aligned with the IFRC and other international and national OVC programme guidelines. Strategic aims were set by the National Societies, which worked with community and national stakeholders to design OVC programmes based on Vulnerability and Capacity Assessments and baseline surveys conducted in programming areas.

The programmes used an integrated community-based approach and focused on an interlinked set of core activities: health, often related to HIV (peer education and information, prevention of mother-to-child HIV transmission etc.), food and nutrition, education, psychosocial support, home-based care, reduction of stigma and discrimination and income-generating activities. In addition, in Lesotho, Rwanda and Burundi, there was an important water, sanitation and hygiene component.

Rwanda: the programme comprised an integrated approach to building resilient communities and ensuring children's improved well-being in line with the Government of Rwanda strategy for OVC programming in partnership with the Norwegian Red Cross, the Finnish Red Cross and the Belgian Red Cross - Flanders.

Zimbabwe: the OVC programming in Matabeleland North and Mashonaland West provinces supported educational support, home visits, prevention activities, etc.

Lesotho: the Lesotho Red Cross Society, in bilateral partnership with Norwegian Red Cross, developed the OVC programme in Maseru and Mafeteng districts and supported children in the following areas: education, access to health including paediatric ART, advocacy, shelter, facilitation of kids' and youth clubs, material support, self-help and income generating activities, food security, psychosocial support and water and sanitation.

Burundi: the programme was implemented in two districts and had an integrated approach to build resilient communities and ensure children's improved well-being with a focus on health, nutrition, education, psychosocial support and socio-economic support, all in line with Burundi Government standards and strategies.

Implementation: trained Red Cross volunteers delivered the minimum package of services. Project staff remained responsible for project planning, gathering data from volunteers, supervising volunteers, organizing and facilitating trainings, distributing materials, and dispensing financial payments for education or health fees/insurance cards.

Community involvement: the community was involved in developing the programme and identifying volunteers. The Red Cross acknowledged the need for programming to be more community-led by shifting toward a decentralized model in which branch committees have more decision-making power.

Volunteers: most volunteers were female, and many were poor and unemployed. Volunteers were active in identifying OVC with input from local leaders (e.g., chiefs, community leaders, teachers or headmasters). Both Zimbabwe Red Cross Society and the Lesotho Red Cross Society provided allowances for the volunteers. National Society personnel noted the need for more clearly defined volunteer roles, development of core competencies and supervisory systems, and the desire to "professionalize" the volunteer cadres. During focus group discussions, Red Cross volunteers in Lesotho, Rwanda and Zimbabwe wanted to be recognized for their work and requested public acknowledgement, identification badges or uniforms, bicycles or other tools with logos.

Liberia

Community-based health care and the ebola outbreak[88]

Background: In Liberia, the Ebola outbreak disrupted health system functioning even further. A study was carried out to examine the value of a community-based health system in ensuring continued treatment of child illnesses during the outbreak and to see whether trained community health workers enhanced access to essential primary health care in a context where the health system lacked capacity to deliver them. It further looked at the role that CBHWs had in Ebola prevention activities.


IFRC/Victor Lacken

Methods: a descriptive observational study design used mixed methods (structured survey, focus group discussions) to collect data from CBHWs, government health facility workers and project staff. Monthly data on child diarrhoea and pneumonia treatment were gathered from CBHWs' case registers and local health facility records.

Results: coverage for community-based treatment of child diarrhoea and pneumonia continued throughout the outbreak in project areas. A slight decrease in cases treated during the height of the outbreak, from 50 to 28 per cent of registers with at least one treatment per month, was attributed to directives not to touch others, lack of essential medicines and fear of contracting Ebola. In a climate of distrust, where health workers were reluctant to treat patients, sick people were afraid to self-identify and caregivers were afraid to take children to the clinic, CBHWs were a trusted source of advice and Ebola prevention education. These findings reaffirm the value of recruiting and training local workers who are trusted by the community and understand the social and cultural complexities of this relationship. "No touch" integrated community case management (iCCM) guidelines distributed at the height of the outbreak gave CBHWs renewed confidence in assessing and treating sick children.

Conclusions: investments in community-based health service delivery contributed to continued access to lifesaving treatment for child pneumonia and diarrhoea during the Ebola outbreak, making communities more resilient when facility-based health services were impacted by the crisis. To maximize the effectiveness of these interventions during a crisis, proactive training of CBHWs in infection prevention and "no touch" iCCM guidelines, strengthening drug supply chain management and finding alternative ways to provide supportive supervision when movements are restricted are recommended.

South Sudan

Providing community-based interventions to increase access to health

South Sudan, heavily impacted by a protracted conflict, faces deterioration of its already-weak health systems. It has very high infant and maternal mortality rates and a large burden of communicable diseases. Access to health care is limited with a majority rural population, only 22 per cent of health facilities that are fully functional, attacks on health workers and health facilities coupled with shortage of medical drugs and health professionals. With the goal of improving the effectiveness and efficiency of the community health sub-system and increasing access to healthcare, the MoH launched the Boma Health Initiative (BHI). It focuses on empowering communities to access high impact, cost-effective primary health care services. Boma is the smallest geographical area and administrative unit consisting of villages and households.

The South Sudan Red Cross (SSRC) in partnership with the Canadian Red Cross launched the "Improving Maternal, Newborn and Child Survival" project in Warrap State, South Sudan in March 2014 in close collaboration with the South Sudan MoH in all nine payams (administrative area) of Gogrial West County, Warrap State.

The project aims to reduce maternal, newborn and child mortality by raising awareness of, demand for, and access to a range of health services at the community level, including iCCM, health promotion and disease prevention, water, sanitation and hygiene (WASH) and capacity building in a range of areas by recruiting, training, equipping and supervising volunteers and communities.

Boma Health Committee: It is comprised of 9—11 members and it guides the Boma Health Teams on implementation of approved activities in communities and reviews programme reports and resource use for accountability and resource mobilization.
A Boma Health Team consists of three salaried CBHWs comprehensively trained to deliver the service package for the BHI. They are residents of the Boma and are selected by their community.

Home Health Providers (HHPs) carry out community mobilization for health programmes, health promotion, disease prevention, treatment and rehabilitation services. They also collaborate with health facilities and Basic Health Teams to follow up on health service delivery including home-based treatment, follow-ups, defaulter tracing, quarantine and referrals. Lastly, they offer selected community-based health interventions, commodities, tablets as prescribed by the "Basic Package of Health and Nutrition Services 2011". They are provided a monthly incentive following negotiations between the SSRC and MoH (750 South Sudanese Pounds per month (approximately 5.7 CHF)).

Supervision of CBHWs is done by SSRC Health Officers and of HHPs by CBHWs. Tools for supervision were adapted from pre-existing SSRC and MoH tools for Health Promotion and iCCM.

Myanmar

Community-based health development programme 2012—2017: lessons in sustainability

The Myanmar Red Cross Society (MRCS) in partnership with the Danish Red Cross and the British Red Cross set up the Community-based health development (CBHD) programme (2012—2017). The programme targeted 26,816 people including 8,700 women of reproductive age and 3,100 children under five years of age in 75 remote rural areas, and communities of ethnic minorities that were excluded from, or had limited access to, essential health services.

Key programme components/interventions were based on the "continuum of care" concept and included: a) improving practices of and access to reproductive health, antenatal care, delivery, postnatal and newborn care, b) enhancing community resilience to most common communicable diseases, c) enhancing access of communities to improved water solutions and hygiene and sanitation practices and d) strengthening capacities of MRCS in community-based health development.

Overall, the access and availability to quality care and the maternal, newborn care and child health practices improved within all townships. Essential antenatal care services were routinely utilized by the population at regular frequency and birth attendance by a skilled health provider (mainly auxiliary midwives (AMWs)) increased significantly. Practices related to early response to common child health conditions (namely diarrhoea, acute respiratory tract infection and malaria) improved as well as immunization coverage and child nutrition practices.

Sustainability, ownership and capacity development of MRCS

Building on existing structures and national strategies: The programme applied national priorities and standards in development of community health. Furthermore, it did not establish new structures but strengthened existing ones at community, township and national level including community health committees, CBHWs, AMWs, township health authorities and staff, and MRCS HQ and township branches.

Community-based approach for delivering key interventions: All key services were delivered by the inhabitants of target communities themselves. At community level, the programme aimed at one CBHW/Red Cross volunteer per 15 – 20 households in each target community. The CBHWs/Red Cross volunteers were responsible for day-to-day community management and mobilization in implementation of programme activities.

Balanced approach to investment in soft and hardware: Investment in infrastructures (e.g. water sources) was supported by sustainability measures.

Connection to and coordination with the existing public health system: Key activities (e.g. training and supervision of CBHWs and AMWs) were developed in close cooperation with the public health system and programmes (e.g. immunization, nutrition and malaria prevention and treatment) as a further measure for ensuring sustainability and broader ownership for the programme interventions.

Exit strategy incorporated into programme design: In order to avoid communities' dependency on outside support, the programme applied three-year phases of active capacity-building of each target community and MRCS township branch followed by a one-year follow-up phase. This time limit was clearly articulated to the target communities from the beginning of the programme. It was anticipated that this timeframe, coupled with the community-based approach and communities' co-contribution with resources (e.g. for constriction of water sources), would be sufficient for target communities to realize the positive health impacts of behavioural change as well as to take ownership and build their own capacities, resources and mechanisms so that communities may help themselves after the programme ended.

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Annex 2:
Examples of existing Red Cross Red Crescent CIC programmes

Red Cross Red Crescent Reference Group for Global Health – May 17, 2019

Note: These guidelines are primarily focused on CBHWs but they are relevant and applicable to other types of community-based health workers, defined in the context of this document as **"health workers based in communities** (i.e. conducting outreach beyond primary health care facilities or based at peripheral health posts that are not staffed by doctors or nurses), **who are either paid or volunteer**, who are not professionals, and who have fewer than two years training but at least some training, if only for a few hours".

WHO guideline on health policy and system support to optimize community health worker programmes – October 2019

Country	CBHW nomenclature used	Since (year)	incentives/ contributions provided	Clinical, screening, diagnostic and curative services	Disease prevention, and rehabilitation	Counselling, motivation and referral skills	Community mobilization, engagement	Supervision, data collection, management and administration
Benin	Health Volunteers		Per diems		Nutrition, hygiene promotion, WASH, HIV, epidemic control, ANC visits, Mothers Club		Sensitization/ home visits and linking households with CBHWs	
Botswana	Level 1 and 2 CBHWs (lay health worker/ paraprofessional volunteers)		Allowances for meals and transportation		OVC programmes, facility-based rehabilitation, health promotion for communicable diseases		Community first aid, road safety, community wellness programmes, home visits	
Burkina Faso	CBHWs, Volunteers		Community recognition, income generating activities					
Burundi	Community health volunteers Youth sections, but work at schools (blood donation, HIV, hygiene)	2018	Communication and transport expenses (if CBHW is required to travel 50km or more for work) are covered. Snack provided if work more than 2 hours per week. Training and equipment provided. The Finnish Red Cross supports a health-integrated programme for volunteers. 2 types at community levels: 2 volunteers + 1 CHW and/or 4 volunteers	Belgian Red Cross supports iCCM work in alignment with MoH strategy. MUAC screening and management of mild to moderate malnutrition.				There is a paid focal point working with the MoH to supervise the CBHWs.
Burundi	Volunteers, Community extension workers, Volunteer brigades		Entitled to allowances if they work more than four hours.		Epidemic control, malaria prevention, TB, HIV, STI, blood donation, referrals			

Country	CBHW nomenclature used	Since (year)	incentives/ contributions provided	Clinical, screening, diagnostic and curative services	Disease prevention, and rehabilitation	Counselling, motivation and referral skills	Community mobilization, engagement	Supervision, data collection, management and administration
Central African Republic	Community-based volunteers		Per diems	Screening and care and support	Community-based surveillance, immunization, psychological support	Counselling on disease prevention, counselling mothers on newborn care management, counselling skills for encouragement of exclusive breastfeeding	Treatment adherence for ARVs	
Ethiopia	Professional and non-professional volunteers		Per diems/ certificate upon request	Case identification, follow up on treatment, screening at community level	WASH, psychosocial support		Home visits, social mobilization, immunization registration, defaulter tracing, surveillance	
Gabon			Per diems according t o donor requirement	Follow up of patients on TB treatment, active search of those lost to follow-up	Nutrition education, family planning, MNCH, sexual and gender-based violence prevention, HIV and STI prevention, disaster risk reduction		In Global Fund TB project, volunteers carry out DOTS	
Gambia	Volunteer, Community Health Worker, Professional Volunteer		Per diems and food	MUAC screening, immunization	Disease prevention, family planning, WASH, MNCH		Social mobilization, house to house sensitization, linking families to health facilities, MNCH	

Country	CBHW nomenclature used	Since (year)	incentives/ contributions provided	Clinical, screening, diagnostic and curative services	Disease prevention, and rehabilitation	Counselling, motivation and referral skills	Community mobilization, engagement	Supervision, data collection, management and administration
Kenya	Community Health Workers/ Volunteers (CHW/CHV) The majority of CHWs are also Red Cross volunteers	Seven years	Payment varies: stipends of 2,000 KS CHF 19/month are provided by government or partners. Each CHW has 50—100 households and they need to demonstrate in their reports that they have visited each household twice during the month. Some incentives are income generation activities. Kenya Red Cross covers medical insurance for all volunteers and trains, equips and supervises them.	iCCM malaria, diarrhoea, pneumonia, family planning distribution, NCD screening, treatment and adherence		(Basic first aid)		
Kenya	Red Cross volunteers / Non- CHWs	Since Kenya Red Cross started	Volunteer management guidelines used to manage volunteers. Volunteers get equivalent of CHF6/day for every engagement to cover transport and lunch (may depend on the engagement). They are trained and equipped. They are all covered by the global Red Cross Red Crescent volunteer insurance.			(Basic first aid)		
Kenya	Surge teams (professionals who then volunteer)	10 yrs +	Needs-based during emergencies. Professional fee (consulters or locum). Costs covered.					

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	CHV and KRCS volunteers		Monthly stipend	iCCM	Health promotion, MNCH services (danger signs and referral), exclusive breastfeeding, sexual and gender-based violence prevention, disease prevention, immunization, family planning		Home visits, referrals, magnet theatre, public address, integrated medical outreaches - immunization, nutrition, MNCH, family planning	
	Visiting nurses and case managers (paid staff)	2000	CHF 200 per month – part time (4—5 hrs per day).	Support, consult with TB patients. Video DOTS.	Referral			Report to coordinators and senior visiting nurses depending upon HQ and branches.
Kyrgyzstan	Volunteers (community leaders) and TB case promoters	2000	Incentives – include transport expenses, mobile cards, CHF 20 per person per month – 200 households per volunteer, per year – at least 3—4 times/year	Door to door visits, stigma and discrimination, screening, referrals, follow up, support to vulnerable people – further prevention, side effects, compliance, information and accompaniment to laboratory and social services, nutrition support, support in terms of cash transfer programming	Information sessions, hygiene promotion, nutrition	Counselling	Yes, during disasters	Report to visiting nurses
Kyrgyzstan	Visiting nurses and case managers (paid staff)	2000	CHF 200 per month – part time (4—5 hours per day).	Support, consult with TB patients. Video DOTS	Supervise the patients with volunteers and provide support to patients and link them with facility			Report to coordinators and senior visiting nurses depending upon HQ and branches.
	Volunteers (community leaders)	2016	Incentives – include transport expenses, mobile cards, CHF 20 per person per month – 20 households per volunteer, 2—3 times /year	Eye care, cataract, trauma, infections, screening referrals, follow-up, accompany to health facility	Hygiene promotion		Yes	Reports to officer in each branch

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Malawi	CHWs, Volunteers		Food parcels, t-shirts, per diems		Health promotion and family planning	Counselling on disease prevention, counsel mothers and caregivers for newborn care management, counselling for encouragement of breastfeeding, prenatal and postpartum counselling	Home visits, social mobilization, linking families to health services	
Niger	CHWs, community mobilizers, volunteers		Per diems for short duration activity, monthly allowance for long duration activities	Clinically trained volunteers take part in clinical interventions at the primary healthcare level	Community-based surveillance, nutrition screening, psychosocial support, MNCH, promotion of exclusive breastfeeding	Referrals and linkages to facilities	Home visits, data collection, community feedback, community needs assessment	
Nigeria	Red Cross volunteer (geographically based) Community first aid teams	2014	Only cover out of pocket expenses. (transport, food)	MUAC screening, iCCM diarrhoea, malaria, pneumonia (partner-supported), surveillance for polio and case finding, distribute condoms, vitamin A supplementation, Partners are UNICEF, WHO, IFRC and ICRC for equipment, training, supervision, joint supervision with the government.				
	Health professional (Red Cross volunteer and staff)	Long time	No payment					
	Volunteers, Community Health Extension Workers		Per diems, monthly allowances, transport reimbursement		Awareness raising, family planning, newborn care.	Counselling, verbal referrals		

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Rwanda	Volunteers		Transport fees, per diems		Health promotion, family planning, newborn care, breastfeeding, nutrition	Verbal and practical referrals	Home visits, peer education, linking families and communities to health facilities, blood donation, epidemic preparedness, vaccination campaigns	
Santa Lucia Red Cross Marva	Red Cross volunteer (provide service)		Situation based, paid per diems. Volunteers are reimbursed for expenses (meals, transport)	Opportunity based, HIV rapid testing in collaboration with the MoH Johns Hopkins Program for International Education in Gynaecology and Obstetrics (JHPEIGO) protocols. (Needs-based, not routinely funded). Distribute condoms Since 2018 in emergency situations they also started doing blood testing and pre-hospital care, using ambulatory bags				
Senegal	Level 1 and 2 CHWs (lay health worker/ paraprofessional volunteers)		Per diem, telephone credit cards.	Follow-up at community level, ORS, zinc	Community-based surveillance, active case finding		Follow-up at community level, bed net distribution	
Sierra Leone	Basic health provider volunteers						House visits, social mobilization, linking families with health services for immunization, public campaigns on health, mobile cinema shows, youth peer educators' sessions	
Somalia			Allowance when they move out of their residential areas or do extra duties	Immunization, oral rehydration in diarrhoea outbreaks	Family planning	Counselling on disease prevention, health promotion	Home visits, social mobilization, linking families to health services, garbage disposal, hygiene promotion, iCCM, ORS in outbreaks.	

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South Africa	CHWs, Volunteers		Programme-dependent stipends		Counselling on disease prevention, health promotion, and family planning	Counsel mothers and caregivers for newborn care management, counselling for encouragement of breastfeeding, prenatal and postpartum counselling, referral for curative services	Home visits, linking families with health services, disease surveillance, screening services, community testing	
South Sudan	Community-based volunteers	2017	Volunteer cost recoveries/per diems		Health promotion, disease prevention	Referrals	Home visits	
Suriname	Red Cross volunteers	Long time	Per diem system based on hours they work, but this is project-based	Blood pressure (2017) Blood sugar, Body Mass Index, HIV counselling and testing				
	Health assistant team	Long time	Fee – one hour is $4.50. Suriname $ (not even $1 US)	Triage and stabilization				
	Community action team (not all are volunteers)	2011	Project based – cost covered (transport, food, etc.)	Blood pressure (2017), blood sugar, Body Mass Index, HIV counselling and testing				
Suriname	Psychosocial support volunteers (5 psychologists)	2013	Expenses covered and fees paid.					
Togo	Volunteers		Per diem transport reimbursement		MNCH, sexual and reproductive health, malaria, immunization, family planning, handwashing promotion.		ACT distribution, albendazole and vitamin distribution	

Country	CBHW nomenclature used	Since (year)	incentives/ contributions provided	Clinical, screening, diagnostic and curative services	Disease prevention, and rehabilitation	Counselling, motivation and referral skills	Community mobilization, engagement	Supervision, data collection, management and administration
Uzbekistan	Volunteers, medical students / nurses	1991	Depending upon branches, transport allowances, incentives for travel to historical sites. After 2—3 years the National Society awards best volunteers incentives like mobile phone.	Older/disabled people, care and support for TB, HIV, NCD, cancers and other Illnesses, specifically blood pressure measurement, screening and other signs of illnesses, support with groceries, drugs, nutrition, cooking, social support in terms of cash transfer programming, housekeeping, cleaning and home based care	Education messaging	If needed, accompaniment for screening and diagnosis to hospitals	Yes	Volunteers report to nurses or director
Uzbekistan	Nurses – paid	1991	Salary – CHF 50-100	3000 older/ disabled people, supervision of volunteers, support older persons, work as medical social workers, support clubs and holidays for social inclusion, legal advice, accompaniment to hospitals and management of compliance of treatment if needed, healthy lifestyle, resource mobilization at local levels, for example wheelchair for disabled.	Health education	Linking with government facilities for counselling		Branch directors

The Fundamental Principles of the International Red Cross and Red Crescent Movement

Humanity The International Red Cross and Red Crescent Movement, born of a desire to bring assistance without discrimination to the wounded on the battlefield, endeavours, in its international and national capacity, to prevent and alleviate human suffering wherever it may be found. Its purpose is to protect life and health and to ensure respect for the human being. It promotes mutual understanding, friendship, cooperation and lasting peace amongst all peoples.

Impartiality It makes no discrimination as to nationality, race, religious beliefs, class or political opinions. It endeavours to relieve the suffering of individuals, being guided solely by their needs, and to give priority to the most urgent cases of distress.

Neutrality In order to enjoy the confidence of all, the Movement may not take sides in hostilities or engage at any time in controversies of a political, racial, religious or ideological nature.

Independence The Movement is independent. The National Societies, while auxiliaries in the humanitarian services of their governments and subject to the laws of their respective countries, must always maintain their autonomy so that they may be able at all times to act in accordance with the principles of the Movement.

Voluntary service It is a voluntary relief movement not prompted in any manner by desire for gain.

Unity There can be only one Red Cross or Red Crescent Society in any one country. It must be open to all. It must carry on its humanitarian work throughout its territory.

Universality The International Red Cross and Red Crescent Movement, in which all societies have equal status and share equal responsibilities and duties in helping each other, is worldwide.

For more information on this IFRC publication, please contact:

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